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A BRIGHAM X-RAY CONFERENCE*

— Medical and Surgical Cases —

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THIS IS an example of the teaching exercises which we have used at the Peter Bent Brigham Hospital for thirty or thirty-five years. It exemplifies free discussion and evaluation of all aspects of selected cases, not just diagnosis, but therapy, follow-up and mistakes, and I think problably we we will learn more from our mistakes than from our triumphs, but I shall let you judge the value of the various parts as the cases go on.

First, I should like to present my colleagues, Dr. Samuel A. Levine and Dr. J. Englebert Dunphy.

The first case is one primarily for Dr. Levine.

The patient was a charming thirty-four year old young lady, and the older we get, the more charming the young ladies look. She came in because she was weak, tired and short of breath for six months. Why she came to Dr. Levine, I don't know, because she had no history of rheumatic fever. Ten months ago, her physician told her she had a slight heart murmur. She herself noticed that she began to be short of breath, first, on climbing stairs, six months ago; then a marked shortness of breath developed, and the heart became irregular.

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She had lost twenty-five pounds of weight, in spite of a good appetite.

Every now and then in our experience, a word or a phrase coming out of the blue sometimes rings a bell, and I am sure Dr. Levine is palpitating right now, yes, palpitating, with that last statement, that she had lost twenty-five pounds of weight in spite of a good appetite. What does that mean to you, Doctor?

Dr. Levine: You know what it means. I taught you what that means about thirty years ago.

Dr. Sosman: It means diabetes.

Dr. Levine: Yes, diabetes.

Dr. Dunphy: Or hyperthyroidism.

Dr. Sosman: She was able to lie flat on the bed, in spite of fluid in the chest and edema. Dr. Levine saw her and found that the right chest was flat. That it was flat to percussion, I mean, and not to palpation. She had a great, true, systolic murmur, but no diastolic. The heart was grossly irregular. She was not cyanotic, and the neck veins were moderately distended. He thought possibly it was rheumatic heart disease, with mitral stenosis, because cases do occur without the typical diastolic murmur, I am told, when in failure or fibrillating. There was also pericarditis, and because of the right chest full of fluid, there was the possibility of mediastinal pathology.

Can you reconstruct what you did at that time, Dr. Levine?

Dr. Levine: I might interject here that she was sent down from Maine by a very good doctor; he was worrying about her right then. He said he had never made a diagnosis of pericardial constriction. Might this be a case of pericardial constriction? He had read that such cases can have fluid, and lie flat. That was the striking thing. She had a lot of fluid in the chest, 2,000 c.c. Could it be pericardial constriction?

He found a venous pressure of 280, which would also make one think of that because the pressure

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rises to a high level. He wanted to be sure he wasn't overlooking incurable disease. It was along those lines that he was thinking when he sent the patient down to me.

There was that possibility and we couldn't dismiss it lightly.

Dr. Sosman speaks about not hearing a murmur. I did not hear it. She looked like a case of mitral stenosis. Every morning when we came in, there would be a question of the diastolic murmur, and the third heart sound would be heard. I was flirting with something going on there, although I thought it might be a stenosis as the most likely diagnosis.

There was no history of fibrillation.

There were other things that developed which pointed in that direction.

I think that we can now go to the roentgenograms for help, Dr. Sosman.

Chairman Sosman: There is a rather striking appearance on this film of December, 1940. The right chest is completely full of fluid, and there is no fluid at all in the left. It was impossible to say, really, whether the heart was enlarged or displaced to the left. I asked them to take out a little of the fluid, which they did. The fluid was clear.

It looks as if the heart is definitely enlarged to the right, Doctor. Do you agree on that?

Dr. Levine: Yes, that is right.

Chairman Sosman: Things are not always what they seem, even in the X rays. Here is what appeared to be the border of the heart, and here is the border of the lung, with fluid. The heart border is here [indicating].

There are other things besides the X-ray film that we use in our roentgenological diagnosis. The one thing was that as I took hold of her hands to put her in the proper position, the hands felt unusually soft. She was warm; she was warmer than usual. When I watched her under the fluoroscope, this whole border of the heart had a hyperactive beat, the type of thing we see with anemia, or hyperthyroidism. So the combination of this hyperactive beat and the warmth and the softness of her skin made me think she probably had hyperthyroidism, with heart failure, and this great mass of fluid on the right.

What did you do next, Dr. Levine?

Dr. Levine: She had been in the hospital for some days and I believe the cholesterol was found to be low, 135 or 140.

Chairman Sosman: I have 170 here. It varied, I know.

Dr. Levine: That means that you think more of thyrotoxicosis. And secondly, the blood flow; she had a fast circulation time.

With this degree of failure, then, I think again of the two points that Dr. Sosman mentioned, anemia and thyrotoxicosis.

Chairman Sosman: You don't get it from diabetes?

Dr. Levine: No. We started to have quite a bit of information, pointing to thyrotoxicosis. A B.M.R. was done, and it was plus 40. Now a B.M.R. of plus 40, in a person with all of this fluid might be ascribed to the heart failure itself. We are taught that failure produces an elevated B.M.R., but that happens even less often than we are led to believe. She had no exophthalmos. And I guess you didn't mention that the left auricle was thought to be posterior on the first examination.

Chairman Sosman: That might fit in with the mitral stenosis.

Dr. Levine: We had much to point toward mitral stenosis; there was everything that you needed for a diagnosis of mitral stenosis, except an honest diastolic murmur. This was in 1940, when mitral surgery was not being performed. We chose to lean toward the diagnosis of the condition that we could do something for; and we treated the patient for thyrotoxicosis.

Dr. Sosman: Did you do any tests for therapy?

Dr. Levine: She had some here, and also up in Maine. We started her on the customary therapy in vogue at that time, which I still think is very good; Lugol's solution, followed by a subtotal thyroidectomy.

She did not respond to digitalis, but did respond to Lugol's.

The thyroid was taken out. Is there much risk in doing a thyroidectomy in these patients?

Dr. Dunphy: Did she have an enlarged gland?

Dr. Levine: It wasn't palpable.

Dr. Dunphy: I think the risk, here, is very low. I don't want to quote Dr. Levine, but I think I am correct in saying that about the first one hundred cases operated upon in this general group of patients did very well. There were one or two deaths. Is that correct?

Dr. Levine: Not in the first 99; there were no operative mortalities in 99 consecutive thyro-cardiacs. And I might say that all had objective evidence of failure, but in 99 consecutive cases, there were no deaths. Just about the time the paper appeared, the 106th case was the first fatality.

Dr. Dunphy: I feel that by and large, despite Dr. Levine's enthusiasm, it is wise to give these people a course of propyl, if they really have much hyperthyroidism, because you can then operate on large or difficult glands, and it is a great comfort to the surgeon.

Dr. Levine: Do you have in mind surgery, eventually, in those people for whom you would advise propyl, or do you hope to get by with that alone?

Dr. Dunphy: I should think that propyl would

be purely a means of preparing the patient for surgery, particularly in the thyro-cardiac.

I would like to ask you a question on this point, because I have seen several patients, one with you, in whom auricular fibrillation was not controlled by propylthiouracil but was reverted more easily after an operation. I have seen it in five or six cases.

Dr. Levine: I think that is true. These propyl preparations came into use in more recent years, and we get into habits that we have had for a long time. This has been a habit of mine and I can talk about the early days because those are the ones I lived through. I don't think I will have 99 cases of thyro-cardiacs in the years to come. People treat them very well, so that now I don't see many of them.

I would like to say a good word for the old-fashioned methods of therapy, carried out by careful surgeons. As I say, there is little or no mortality, and you can have a surgeon give you back the living patient, and you won't get complications of medical management.

As a matter of fact, this patient did not stop fibrillating after thyroidectomy. After the operation, she was still fibrillating. We wanted to finish the job and send her home as well as we could; we were still wondering whether she had mitral stenosis. There was still this questionable third sound.

Dr. Sosman: This was a follow-up, four months after the operation [showing film], as you can see here. I maintain that she was still having the signs of mitral stenosis.

Dr. Levine: She didn't have objective signs clinically. Two weeks post-operatively, she returned to the normal rhythm.

Dr. Sosman: This is the 1941 X ray.

Dr. Levine: Did that disappear entirely? At least clinically, there were no signs of mitral stenosis; years later she was well and has been well ever since.

Chairman Sosman: Are there any questions from the audience? Probably you have seen cases like this yourselves. Here are two men who know how to pick them out, and tell them about their ailments.

Question: If you had this patient now, would you want to know the radioactive iodine uptake before making the diagnosis?

Chairman Sosman: He wouldn't know what you mean, but go ahead and answer him.

Dr. Levine: If you work around a hospital like the Rhode Island General or the Peter Bent Brigham, the residents or house officers would ask for it, or do it without even asking for it. I think in a case like this, I would have some doubt about it. She would have a high R.A.I. uptake and that would clinch the diagnosis. But, if I had enough of a clinical hunch that thyrotoxicosis was present, I would not care too much if the other tests were not convincing; I would still stick to my diagnosis.

I had a patient with thyrotoxicosis, with a mediastinal goiter and the R.A.I. uptake was normal. Whether the examiner had the counter over the area, or the toxic part of the gland, or the mediastinum, and whether she had eaten fish or taken something that vitiated the test or not, I do not know what went wrong with the test, but it was normal. But, the patient had thyrotoxicosis.

Question: I want to ask Dr. Levine this question. In the presence of that extensive amount of fluid, why is there evidence only on the right side, if the condition is considered to be on the basis of cardiac failure?

Dr. Levine: That is a good question. I do not know why it was all on the right side and the left side so clear. I could not understand it.

Dr. Dunphy: Have you ever seen this before or since, so much fluid in a patient with cardiac failure from hyperthyroidism?

Chairman Sosman: It is quite rare. I do not remember any other striking case.

Dr. Levine: Not the unilateral type of this kind. Bilateral hydrothorax, yes; it is customarily seen in congestive failure. That is not so rare. However, appearing on the right side and persisting on the right side, after repeated tappings, and the left side remaining clear, I don't quite recall a case like this.

Question: What objective evidence helps the surgeon to determine how much of the thyroid gland to remove?

Chairman Sosman: That is a good question. How do you decide?

Dr. Dunphy: I really don't know. No one knows the answer to that. I think the general opinion is that you should do a generous three-quarters thyroidectomy. Dr. Cutler used to do a radical one; leaving less gland behind and with a little more myxedema. If you are going to err, then err on the side of taking a little too much, rather than too little. Fortunately, by-and-large, we did it fairly accurately. I think the reason is that in some curious way the thyroidectomy breaks up the hormonal cycle of the disease. The remaining thyroid does not show a hyperplastic gland, after you have taken it out when you have occasion to re-operate for some other reason.

Question: What about the histology?

Chairman Sosman: It was a typical hyperplastic gland of hyperthyroidism.

Question: Was the pleural effusion, which occurred at the onset, a stimulating factor in the development of the hyperthyroidism, or associated with it in any way?

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Dr. Levine: I doubt it very much. There was nothing in the lungs. With recurrent pleurisy of a tuberculous nature, there is fever.

Chairman Sosman: The fluid was examined for tuberculosis and tumor; it was not inflammatory fluid; it was the cardiac type of fluid.

Question: Would X-ray therapy have been considered in this type of thyroid?

Chairman Sosman: Thirty years ago. But they do such a beautiful surgical job now that X rays have gone by the board.

Question: How does Dr. Dunphy feel about the Lugol's instead of propyl?

Dr. Dunphy: You should give Lugol's as part of the preparation; you should give them both. I feel, as Dr. Levine does, that the record with Lugol's, particularly in the mild and intermediate degrees, has been so good that if you have some intention of getting on with the job, it is important.

A good example of mine not long ago, was a patient with a neoplasm and hyperthyroidism, the neoplasm being elsewhere in the body. You don't want to do a major operation on a patient with hyperthyroidism. So we prepared with Lugol's. And in a case like that, you could also use propyl.

I would like to say a word about radioactive iodine, which is going to come up for discussion. It certainly is an effective way to treat hyperthyroidism. Our feeling, and I think the feeling of the majority of surgeons in this country, with few exceptions, is that for treatment there ought to be some little time reserved for patients who are considerably older than this patient, or patients with recurrent hyperthyroidism, but not for the younger people.

I would like to say a word about the uptake, because I think it is just as unreliable as the basal metabolism. The uptake is not going to give you the absolute answer. The iodine is the most reliable single determination. Whether it is due to their having had a little iodine in one form or another in the past, the fact remains that you will get a normal uptake in people who your judgment tells you have the mild type of hyperthyroidism.

Second Case

Chairman Sosman: Let us go on to the next case. This is for Dr. Dunphy, and it concerns a fifty-year-old woman, who came from Pawtucket. She had rheumatism in her hands, weakness, night sweats, loss of weight, and an abscess in the buttocks. She came to Boston with all of this trouble. She was an unusual person; she was married at sixteen, and divorced at twenty-four. She had eight years of married life, during which time she had three children and four miscarriages. She had always worked for a living, working long hours and was poorly paid; she lived under poor conditions.

She had had the stiffness of her hands for about five years. The abscess was a recent thing of about eight months' duration. Although she was fifty years old, she didn't look fifty, she looked eighty years old. She was a haggard, old lady; she was apprehensive and anemic. And the anemia is going to come up several times here. Our first lady with the hyperthyroidism was a little anemic.

Dr. Levine: She had a dash of anemia, so to speak.

Chairman Sosman: Does that come in hyperthyroidism?

Dr. Dunphy: Not particularly, no.

Chairman Sosman: She had a pulse of 115, and a fever. The blood pressure was 110/75. She weighed 100 pounds.

The doctors felt a large, hard, movable mass, down to the iliac crest, deep in the flank, with a notch on its medial edge. Can you tie up the anemia there?

Dr. Dunphy: I would think, immediately, that this was an enlarged spleen.

Chairman Sosman: The white blood count was 7 to 11. The urine was negative. Gastric analysis, no free hydrochloric acid. Is that one of those tests which is always right?

Dr. Dunphy: It is a pretty good test.

Chairman Sosman: They thought she had a tremendous spleen and an anemia associated with the spleen. They gave her a swallow of barium, to see what the spleen was doing to the stomach.

Dr. Dunphy: I remember this patient, because on February 21, 1933 [referring to the date on the X-ray film], I was a house officer.

Chairman Sosman: Did you help Dr. Cutler deliver this [still referring to the film]?

Dr. Dunphy: No; I wasn't old enough at that time to help him; I had to watch from the side lines. It was some kind of a trichobezoar.*

Chairman Sosman: That is a very interesting word. Where does it come from? Did you bring your dictionary with you?

Dr. Dunphy: Doesn't it mean a ball?

Chairman Sosman: We have a walking dictionary here. Well, the surgeons got at it; they did a transverse incision from flank to flank and put four hands in, two men with two hands each, and delivered the stomach, as you would deliver a baby. It was almost a baby. Anyway, they delivered this

*Trichobezoar — a hair ball in the stomach or intestine. "BEZOAR. Persian *padzahr;* from *pad* = against, and *zahr* = poison; corrupted to *bezoar* = antidote. The ancient Persians believed that the substance of these hair balls, or food balls, from the stomachs of animals, had a great virtue as an antidote against any poison. A PHYTOBEZOAR (Gr. *phyton* = a plant) occasionally occurs in man from eating unripe persimmons." (Pepper, O. H. Perry, M.D. MEDICAL ETYMOLOGY. W. B. Saunders Company, Philadelphia, London, 1949.)

peculiar mass, which, as you see, is made up of curly hair, and you can see it all around, here [indicating]; you can also see the centimeter rule, beside it.

How does that fit in with the anemia and all the other things?

Dr. Levine: Did the hair get gray in there?

Chairman Sosman: It was black, curly hair.

Dr. Dunphy: There are a couple of points about this case. It is interesting that she had no free acid, because that is not necessarily true in these cases; they probably weren't testing gastric juices. These patients may have gastric or peptic ulcerations in association with their ailments. If she did, is there some other cause for the anemia, although I think a number of the patients with this disease do develop secondary anemias on a malnutrition basis.

Chairman Sosman: Are there any other comments?

Dr. Dunphy: I am trying to remember, but did she admit, finally, eating her hair?

Chairman Sosman: Yes. Those were the days before the psychiatrist had an office in the hospital. She finally admitted that when she was working in the mattress factory in Brockton, she used to take a handful of the black hair and chew it, just as some of you are chewing gum at this moment. And, of course, some of it would get into the stomach. So she had about $7.50 worth of mattress hair in her stomach!

Dr. Dunphy: What about digesting this sort of thing?

Chairman Sosman: They are totally indigestible. I have seen foreign bodies of all kinds and varieties, nails, knives, glass; the Psychopathic Hospital is full of the most amazing variety of foreign bodies, but the trichobezoar produces malnutrition, such as this girl suffered. And, by the way, this trichobezoar is at the Warren Museum at Harvard, if you should want to see it at any time.

You know, some people pull out their own hair and eat it.

Dr. Dunphy: I saw a patient at the City Hospital whose X rays looked very much like this one; before barium was given, there was almost a complete calcification of the stomach. Do you know anything about that?

Chairman Sosman: I would like to see it.

Dr. Dunphy: She happened to have gangrene of one leg, also.

Chairman Sosman: And not the hyperthyroidism?

Dr. Dunphy: No. There was no general calcification of the bones.

Chairman Sosman: And no severe renal disease?

Dr. Dunphy: No.

Chairman Sosman: You get calcium deposits in the lung, and the kidney shows the condition.

Dr. Dunphy: That is not the case here.

Question: Was any other pathology of the stomach known at that time?

Chairman Sosman: It was ulcerated, raw and weeping; that is where the anemia came from, and the foreign body.

Dr. Levine: I think they are all eager to know what happened to her after the operation.

Chairman Sosman: She got over the operation all right. The abscess cleared up, and when we came to follow her subsequently, we found that she had died of tuberculosis. So this abscess in the buttocks was presumably a tuberculous fistula. She died about five years later of tuberculous peritonitis and far advanced tuberculosis of the lungs.

Dr. Levine: No more trichobezoar?

Chairman Sosman: No, but she admitted having one taken out previously!

Third Case

We will go back, now, to Dr. Levine and give him a problem. This is a young man of twenty-three, with very unusual complaints that he brought to the cardiologist. As a matter of fact, he came originally to the Medical Service, because of weakness in his legs. He couldn't stand up. He was irritable, jumpy, hyperactive, like the advanced hyperthyroid patient and he had numbness of the hands and feet. He had dilated pupils. He had a pre-systolic murmur at the apex, third grade, blowing systolic murmur, a blood pressure of 124/62, and the E.K.G. was normal.

Can you make a diagnosis on those non-specific symptoms?

Dr. Levine: I wouldn't be able so far to tell from those data as to what kind of heart trouble he had, or whether he had heart trouble at all. It sounds as if he had something wrong with the heart. Whether it was dilated, we don't know. Evidently, there was no coronary story, valve disease, hypertensive heart disease, or coronary artery disease.

Chairman Sosman: There was a grade 3 blowing, which usually means valve disease.

Dr. Levine: Usually a valve defect, yes, but not always. It means disease, to know a person has a grade 3 systolic murmur. But, it may be found in other diseased conditions, such as anemia, thyrotoxicosis, or something of that order.

Chairman Sosman: Here is the heart [X-ray film], and you can see the pulmonary congestion. The heart has a peculiar triangular shape. According to the laboratory work, the hemoglobin was 72; N.P.N. 55. It was about double the normal, or almost that. The B.M.R. was plus 27.

Dr. Levine: That isn't quite right.

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Chairman Sosman: The venous pressure was 260 per cent. There was obvious heart failure, with the pulmonary signs. So that now, I think Dr. Levine is going to wake up and come to the point. The circulation time was 13.8 seconds.

Dr. Levine: There, you have the same problem, heart failure, rapid circulation time—it makes you think of aneurysm, thyrotoxicosis, anemia, fever, beriberi, something that increases the metabolic rate of the body.

Chairman Sosman: What do you want to know next?

Dr. Levine: You say the E.K.G. was normal, or within normal limits?

Chairman Sosman: Yes.

Dr. Levine: I know the answer, but I am trying to think of the patient before I knew the answer.

Chairman Sosman: How about the circulation time?

Dr. Levine: That would go with all of the things I have mentioned.

Chairman Sosman: Cardiac output?

Dr. Levine: If that were measured, it could be definitely elevated. What about the diet?

Chairman Sosman: It is at least twice normal. He has a high output failure. Why do you want to ask about his diet?

Dr. Levine: That would throw light on the beriberi, if he is living on a queer diet.

Chairman Sosman: He is a taxi driver, who is separated from his wife, and he lives almost entirely on whiskey, and twice a day he has a doughnut.

Now, what about the diagnosis on the X ray here [showing X-ray film]?

Dr. Levine: I don't know that the X ray of the heart would help you unless you find it to be hyperactive. I don't know that that is always the case, unless you do more than X ray the patient.

Chairman Sosman: As a rule, they are hyperactive, with fluid in the lung and the abdomen. In this case, the beat was considerably diminished. We were thinking of constrictive pericarditis, as far as the heart and lungs were concerned. The laboratory findings would not fit in.

Dr. Levine: You can rule that out immediately, by the high output.

Chairman Sosman: I was wondering what was going on. I turned the light on, and there he was over at the door, and I said to him: "Oh, no, I am not through here." So I got him back and put him behind the fluoroscopic screen, and I turned on the fluoroscope, and he was gone again. I asked him what he was doing, and he said:

"I'm trying to kill those goddam rats on the wall."

Delirium tremens and beriberi.

Dr. Levine: That didn't come out in the X-ray film.

Chairman Sosman: No, but you learn a lot in the darkroom. Now, what would you do for him?

Dr. Levine: After getting that clue from the roentgenologist, I would start treating him with thiamine.

Chairman Sosman: We tried digitalis, with no effect. And we put him on thiamine. Here he is again [showing film] with a marked prompt response, and the next film shows him ten days later, March 13th, when his heart has gone down in size and also has returned to a more normal contour.

Again, here is an example of dilated pulmonary artery, and there is a little suggestion of an auricular condition. But, both of them are misleading signs, as in mitral stenosis. You get them sometimes in the high output failures.

Dr. Levine: When there is a rapid flow through the chambers, the chambers can dilate; that is an important point. Also, the rapid flow from the left auricle, or increased flow from the left auricle to the left ventricle, as you see, for instance, in patent ductus, can produce slight diastolic sounds or murmurs, and sometimes they are a little more than slight and may resemble mitral stenosis. In other words, you can get some kind of diastolic murmur, grade 1, grade 2, in cases without mitral stenosis, when there is a large flow in the left auricle and into the left ventricle.

Once in a while, this picture is like a bacterial endocarditis, with some anemia, too, and a murmur, and you can't put your finger on anything else.

I remember a patient who was thought to have bacterial endocarditis; in fact, it was the first case of beriberi heart disease that I had sense enough to recognize. It was called subacute bacterial endocarditis for a week or ten days. I wasn't satisfied with the diagnosis.

Getting the history, we had the first clue. This is all beriberi. It is a wonderful thing to pick it up because you get a good end result, if they stay sober afterwards. Rarely this occurs during pregnancy. I saw one pregnant woman with beriberi heart disease, because of nausea and vomiting of pregnancy; she lived on the wrong diet for some months, developing heart failure, which could be classified. It was a nutritional heart failure. Vitamin therapy was given.

Question: On the first film you showed, it was a fairly large heart, and yet you considered the possibility of constrictive pericarditis. I thought that probably I was misled, that you had a small, silent heart.

Chairman Sosman: The books are all wrong. Practically every book and every article on constrictive pericarditis says it is a small, quiet heart;

well, the quiet heart is all right, but the "small" is wrong. It is not as large as you expect it to be, but almost every constrictive I have seen has had moderate enlargement. It is not the great big heart you would expect to see.

Dr. Levine: Then you live long enough to get a further exception. What Dr. Sosman said is true. A good many of them have slight or moderate enlargement. Two years ago, I had a patient who had pericardial constriction, with three plus cardiac enlargement, proved by operation. That is the only one I have seen of that type. But, the point is well taken. Don't expect to have a small heart; it can be slightly enlarged, or sometimes moderately enlarged, and very rarely markedly enlarged.

Chairman Sosman: Are there any other questions on this case?

Question: What was the course of the electrocardiogram; as the patient improved, did it remain normal?

Chairman Sosman: It says here that he had low voltage, and it became higher, as he got better.

Dr. Levine: I don't remember the details of this particular case, but in general I think what Dr. Sosman said is true. The cardiograms are not normal in beriberi.

Question: What I had in mind is that we saw a patient whose electrocardiogram became more abnormal, as the patient improved. I was wondering, also, how long it takes for evidence of peripheral neuritis to disappear.

Dr. Levine: I am not an expert, to pinpoint that last question, but I would say that my recollection is that the neuritis symptoms, such as the numbness disappeared during the hospital stay, which means a couple of weeks.

Question: I would like to ask Dr. Levine if he sees this form of heart disease very commonly, and how much he depends on the response to thiamine as a therapeutic test to establish the diagnosis.

Dr. Levine: First, I see these very rarely. Probably you might see them more frequently if you were following medical cases in Dr. Dunphy's hospital.

Chairman Sosman: Dr. Dunphy sees a lot of them, but doesn't recognize them.

Dr. Levine: I will take exception to that; he would recognize them, if they should land on the Surgical Service. But, I see them rarely.

As to the second point you asked about, let me say that when you work up a case you always have a period of control. These patients have had a couple of weeks of digitalis therapy. That is wonderful. It proves a point. They don't get better on digitalis. You start them on thiamine, and in a week you see a dramatic improvement, and there is no doubt about the diagnosis. There was not a doubt about the diagnosis beforehand, either. But, if you started them right off with thiamine therapy, and the patient got better, you would be left always in the lurch. You don't know whether the rest in bed or good nursing made the patient get better anyway. When you have a control period, and then you get a specific response to thiamine, then that is it.

Question: Suppose you get a patient who is in failure, and deficiency, and you give them nothing at all, and they are in bed a week. Do you call that deficiency in a young fellow sixteen or eighteen?

Dr. Levine: Those controls are done already; you see, these people are in the hospital, and they are given whatever food they can take, and they don't get better. When you try something like that for two weeks or so, then you do something different. They don't know anything about psychotherapy, and if they improve, there is no doubt about the relationship. If they improve the first week on the diet alone, you might be left in doubt.

Chairman Sosman: You are not sure of that at all, but with controls, the thing is more reliable.

Question: Do you have any evidence of cirrhosis in this patient?

Chairman Sosman: I don't remember about that. He is only twenty-three; but, he will get it before long, if he keeps on.

Dr. Dunphy: I haven't seen any such cases. It is interesting that some years ago, Dr. Ravdin and Soma Weiss pointed out that perhaps thiamine deficiency played a role in the cardiac failure of hyperthyroidism, and that the same mechanism might be operative.

Question: Did he have any other signs or any other vitamin deficiency, besides the thiamine?

Chairman Sosman: It is not recorded here in the history.

Dr. Levine: There is one point that Dr. Dunphy brought up, and I want to pursue it further. These thyrotoxic people often have red palms, but the improvement that takes place under therapy is not the improvement from diet.

Question: On the B_1 deficiency, Dr. Levine, wasn't there some work done at one time where the people on B_1 didn't pass so much urine, and it was used as a test? Did anything come of that?

Dr. Levine: I don't know the details of that.

Chairman Sosman: There is one other thing that we ought to emphasize. This is a dangerous disease, and Soma Weiss really put beriberi heart disease on the map in Boston, at least, and he pointed out that sometimes these patients will die around the fourth, fifth, sixth and seventh day. That might be what you were asking about, a period of worsening before they get better. Perhaps that fits in with your question. He says there is a

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dangerous period in there, and you have got to watch it, before they get better.

Fourth Case

The next case is primarily for Dr. Dunphy, and again, it is a patient with anemia. This patient is sixty-nine years old, and she was a school teacher who was so tired and weak that she decided to retire before she reached the required retiring age. She is only sixty-nine, and they were allowed to go to seventy. The physical examination was entirely negative, except that she was pale.

Dr. John Adams, whom some of you know, lives right across the street and works across the street from the Peter Bent Brigham Hospital; yes, he lives right in the shadow of that incomparable institution, and you would think that he would starve to death, but not at all, because he gets the cases we can't cure and fixes them up! So there is no better place to practice medicine than right across the street from a big hospital. The doctors in Minnesota make a good living, taking care of patients from the Mayo Clinic who don't get fixed up. And perhaps that is why there are so many doctors around the City Hospital in Boston!

Anyway, he found she had a positive guaiac in the stools. He said: "I am pretty sure she is bleeding from the gastrointestinal tract. I want you to find out where. I did a barium enema and gastrointestinal series, so-called, and couldn't find a single bit of evidence of a bleeding lesion."

Dr. Adams put her on liver and iron, but she did not improve. He re-examined the stools and they were guaiac positive.

If she were your patient, Dr. Dunphy, what would you do next?

Dr. Dunphy: Before I did the barium enema, I would have done a sigmoidoscopy.

Chairman Sosman: She had no visible gross bleeding.

Dr. Dunphy: Next, I think that two thoughts would come to mind. First, she is bleeding from the gastrointestinal tract, and secondly she has anemia. It is up to us to pinpoint where this area is.

I take it she was looked over carefully for varices.

Chairman Sosman: Yes.

Dr. Dunphy: One might consider the small bowel, if all of these tests were negative. Knowing how frequently the roentgenologists miss the tumors, particularly in the right side of the colon, I think you would still have to continue to follow her very carefully. One ought to explore rather than delay.

Now, it is assumed that you have done the entire gastrointestinal tract, and that it is negative. We like to hospitalize the patient, put in a Miller-Abbott tube, begin to take aspirations, and when we strike the guaiac positive material, hold the tube there, and put in a little bit of barium. We have picked up some small lesions in the intestines, such as early carcinoma of the small bowel, that you might not find under a routine exploration.

There are some patients in whom you just can't find what they are bleeding from or why.

Did she have a motility series?

Chairman Sosman: We did that next. John Adams asked me: "What shall we do next?" I said: "Are you sure she is bleeding from the gastrointestinal tract, and he said it certainly pointed toward that. So I said: "Let's try the small bowel series, the motility series."

You give the patient a small amount of barium and water, and take a film every fifteen minutes during the first hour; then every thirty minutes for the next hour or two. We look at every film as soon as it is developed. The moment you see something, the patient is taken into the fluoroscopic room and spot films are made of that particular area. That picks up quite a few of the lesions. Even then, we are apt to miss it. Therefore, if we are convinced that there is bleeding, we then use the Miller-Abbott tube, take the samples, and the moment they show the blood, we run in barium and it helps you to know how far down it is, so that later you can explore.

Dr. Levine: Is that the same thing as the string test?

Dr. Dunphy: It is the same idea; both are helpful.

Chairman Sosman: This is the gastrointestinal series [showing film], the beginning of the motility series; this is the stomach up here. You recognize that all right. This is the bowel. We should have cleared the barium out before starting the motility series, because there might be a lesion in the terminal ileum that could be hidden.

That looks like a fairly good pattern until we reach here [indicating on film], and there is something which looks a little abnormal. This is a peculiar ring of the mucosa. At that moment, we stopped the examination, took the patient into the fluoroscopic room and got some spot films. From there on, you see the loss of the normal mucosa pattern, and you have these overhanging edges, looking much like an apple core that a small, hungry boy ate. We felt that this was an ulcerated annular tumor.

What are the chances of its being one of the various types of tumors? What are the chances of curability, and so forth, in your experience?

Dr. Dunphy: The best bet would be a small cell carcinoma, adeno-carcinoma.

Chairman Sosman: Why not one of the spindle cell myomas or sarcomas?

Dr. Dunphy: Well, they certainly occur. I think that just statistically, the small cell carcinomas are very hard to distinguish. You might argue about whether they are of epithelial or spindle cell origin, but I think that most of the time you can call them epithelial rather than sarcoma.

I think that although the ulceration looks rather prominent; one has to consider the lymphomas.

The tragic thing is that these are bad tumors. With this woman at sixty-nine years of age, I would think this was a pretty serious finding.

Chairman Sosman: There was nothing palpable. She had no nodes anywhere. Would you explore her?

Dr. Dunphy: Oh, yes.

Chairman Sosman: She was explored by a friend of yours, Roger Zollinger in May of 1940; he dissected out a section of the small bowel and here is the annular tumor [showing film]. Here is a polypoid; it turned out to be adeno-carcinoma. No nodes were involved. With that degree of removal, is it cured?

Dr. Dunphy: I think she is fortunate if she is cured. I would expect a recurrence. This is a bad tumor, even when there are no nodes.

Chairman Sosman: The lady is still cured and still alive; she is now eighty-four years old.

Now, we will say a word about how much you have to resect, in order to cure primary cancers of the bowel.

Dr. Dunphy: In carcinomas of the bowel, the problem is mesentery resection. The mesentery is really quite small, so that you cannot make a generous resection of the mesentery without taking a tremendous amount of small bowel. The increment of gain, per weight of mesentery, per amount of bowel that has to be sacrificed is tremendous, and even then you are right where you can't go further.

Chairman Sosman: The increment of gain is small, isn't it?

Dr. Dunphy: Yes, even when one does a radical resection; if the nodes are involved, it is serious. This is a good case. I don't happen to know of a long-term cure of adeno-carcinoma of the small bowel. I am sure there are some, but the figures are very discouraging, in comparison with carcinomas where the survival time is greatly prolonged. They may not be cured. They may have deposits of tumor, and yet they may live for many years.

Dr. Levine: How about lymphomas of the small bowel?

Dr. Dunphy: It is a poor place for it. The lymphoma of the stomach has a better prognosis than carcinoma of the stomach. Roughly, lymphoma being confined to the stomach has a fifty per cent. five-year survival, which is far better than that of cases of carcinoma of the stomach.

Chairman Sosman: Are there any questions on this matter?

Question: I should like to ask this question. Assuming we are not fortunate enough to find the tumor, and I am sure you will all admit an occasional lapse, then what next?

Chairman Sosman: Do you put the tube down?

Dr. Dunphy: We would have put the Miller-Abbott tube down, take the films and aspirate for blood. When we found the blood, then we would pull the tube back a bit, because this telescopes rapidly and you get farther down than you think you are. You take another film, and you might pick up the lesion.

But, let us assume that we didn't do that. We would still explore, expose and probably look at the three or four feet of bowel where we thought we got the blood. Actually, I think you are justified in cases with persistent recurrent bleeding, in opening the bowel, as you might find other things as the cause of it.

Question: I would like to ask, was it a flat film that was taken, and also, was there any change in the bowel habits of the patient?

Chairman Sosman: No. And, there was no change in the bowel habits. The lesion was pretty well up in the small bowel; all the content was liquid, and went through fairly easily.

Question: Would blood studies determining the type of anemia help?

Chairman Sosman: Yes; the anemia was secondary, but there was positive guaiac in the stools. John Adams and I were both convinced that she had a bleeding lesion somewhere in the tract, and that one must go on to exploration, if you can't find it. Is that right?

Dr. Dunphy: Yes, that is right. We have also seen small bowel carcinoma, or lymphoma, as the cause of unexplained fever; the only complaint of the patient was fever.

Going through the usual studies, I remember one patient very well; for a little indigestion, some one did a gastrointestinal series which was negative; on the last film, Dr. Sosman noticed a tiny abnormality in the loop of small bowel, which led, by happenstance, to the recognition of a small bowel carcinoma.

Question: In what per cent of the cases, Dr. Sosman, do you think you can demonstrate Meckel's diverticulum?

Chairman Sosman: I have been looking for a Meckel's diverticulum for thirty years, and I haven't found it yet, although I am convinced from the history that there was one there. The only one that I ever diagnosed, was in a fellow who came from the Midwest; he walked in and said he was going to get the proof on this one, and he was right.

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Dr. Dunphy, have you been able to demonstrate it?

Dr. Dunphy: No. We have localized bleeding on that basis, and then found a Meckel's.

Chairman Sosman: That is one of the important things, to find what part of the small bowel the blood is coming from. If we find it in the lower ileum, the Meckel's diverticulum becomes a more prominent possibility.

The benign tumors may bleed, but, as a rule, the benign tumors all go in for intussusception. The ulceration and bleeding are much more of a secondary affair. The adeno-carcinomas are much more common in the upper portion of the small bowels in the jejunum, and the upper ileum, about two to one over lympho-sarcoma. It is just the reverse in the lower half of the ileum, the terminal ileum, the lymphomas are about two to one over the adeno-carcinomas.

Question: How often has Dr. Dunphy encountered cases of gastrointestinal bleeding in which exhaustive studies were done and there was no answer?

Dr. Dunphy: I can recall one patient, who was the father-in-law of a doctor, or related to a doctor's family. He had recurrent, massive bleeding from the gastrointestinal tract, without hematemesis. There were bloody stools. We X-rayed him at the Brigham. We took a G.I. series, and there was a negative barium enema. We did the Miller-Abbott tube maneuver on him, and felt that we got blood from the lower ileum. We explored him and found no abnormality. We opened the bowel and looked into it. We felt very embarrassed, but we couldn't find the site of the bleeding. He went home. He had some hemorrhoids, which did bleed a little, but we really didn't think they were the cause of it, but we wanted him to feel that something had been done, so we fixed up the hemorrhoids. He bled again in about three months, fairly sharply, and then he bled again.

We finally noted that he bled always on a Sunday or a holiday. It was a very interesting thing.

We explored his habits a little more. This is what he did. On the day before a holiday and on a Saturday, he played golf. At night, he played bridge. He drank seven or eight or nine highballs between five o'clock in the afternoon and the time he went to bed. He got up in the morning about ten and took four or five aspirins or maybe six, and a cup of coffee. Then he played golf. The last three times, he was caught, literally, with his pants down; that is, he bled on the golf course.

The only therapy has been to cut his drinking from eight to four highballs, cut out the aspirin and make him eat breakfast. He hasn't bled since.

Question: There is a pretty well documented series in this same respect from the City Hospital on the silent gastric ulcer, at operation or by X ray.

Dr. Dunphy: We are going to come down in May and tell you the answer to that one.

Question: Dr. Dunphy spoke about unexplained fever in malignancy of the small intestine. Harry Steiner of Chicago reported in the JOURNAL OF DIGESTIVE DISEASES on unexplained fever just what you spoke about.

Chairman Sosman: We get it also in other tumors, not only in tumors of the G.I. tract.

Question: In this case, how about doing a Graham test, when you get bleeding from the biliary tree?

Dr. Dunphy: It occurs in tumors; it occurs in silent ulcerating gallstones and in other cases. I think it is a good point. In an exploration, you should always include the biliary tract, when you are operating for bleeding of unknown etiology.

Fifth Case

Chairman Sosman: The next patient is twenty-six years old, female, and has exertional dyspnoea, weakness of the legs and cold feet. The systolic blood pressure, at age 11, was 180, and has remained there more or less ever since. She has a half-sister with atrial septal defect and chronic congestive heart failure.

She came in with a blood pressure of 160/80.

What gives you hypertension in a young person?

Here is a nice problem, that you see every now and then, and how do you go about it?

Dr. Levine: I would like to mention just a prelude to this case. I know all about this girl. The prelude is this. The doctor who sent her up from North Carolina never saw a case of coarctation of the aorta in his life, and that is what this girl had. Perhaps I am throwing the bouquet at myself, but it is a tribute to what is called old-fashioned medical teaching; we can call it a dry clinic, teaching without the presence of the patient. The doctor was up here taking the customary post-graduate course in July, and we do try to cover the things that are worthwhile, even if we haven't any patients to show. I don't pull in patients, for instance, in the case of a patent ductus, if one isn't around, or a case of coarctation; I don't pull in the cases. So we did the best we could, in describing what to look for. This was some years ago. The point to be emphasized is that anybody who has a little elevation of pressure, especially when they are young, and this is standard practice now although years ago it wasn't done, whenever you see anybody with hypertension, you feel the femoral arteries to see whether they pulsate well, or not at all or only feebly, or if the abdominal aorta pulsates feebly or not at all—that is the first step toward the diagnosis of coarctation of the

aorta.

Take the pressure in the leg. We don't do the routine pressure in the legs; it would be awful if we had to do that every time we saw a patient. It isn't easy to do, and it takes time, and you can spend a lot of time uselessly. But, whenever the femoral pulses are decreased or absent, you have to look for coarctation.

This physician went home and ran into a case which, he thought to himself, must be coarctation; he recalled what was taught him. He didn't find the femoral pulse in the groin. The patient was known by other doctors, to have hypertension for years before. He made the diagnosis of coarctation, on simple, didactic teaching. He made a definite diagnosis, and sent her up here.

Then, some interesting endocrinological findings came into play that complicated the problem.

Chairman Sosman: Do you want to describe what you found on physical examination?

Dr. Levine: Another clue is this. Practically all of them have a murmur; it may not be a loud murmur. A grade 1 or 2 systolic murmur, generally is best heard in the second left space. Then the murmur is audible usually between the scapulae. When you hear a murmur only grade 2, front, and you can still hear it in the back, it means something.

When you hear a murmur, Grade 4, 5 or 6, and it is loud, in the anterior chest and you hear it between the scapulae, it doesn't mean anything. But, when they are not so loud in the front, and can still be heard in the back, you think of coarctation.

She had a systolic murmur, Grade 2 or 3, and the murmur in the back; the femoral pulses were practically imperceptible. Pressure of the legs was unobtainable. This is all done before the X-ray data.

Here is a little test that I use; I don't think it amounts to a great deal, but I amuse myself doing it. It is the pressure test on the fingers, the blanching test. You press the tip of the finger, and let go. Then you time how long it takes for the blushing to return. Normally, it comes back in one and a half seconds. The toes may be a bit slower, but even there, the color is apt to return in two or three seconds. These patients will have a one or two seconds time interval for the fingers, or one and a half to two seconds, and five, six or eight seconds in the toes, where there is a poorer blood supply. That isn't pathognomonic. Some people do have a slow return. But, it is striking, the marked discrepancy between the fingers and the toes when you perform the blanching test.

She had symptoms. At this age, some of the patients have very few symptoms. They do, later. She had been short of breath for a long time. She had heavy legs. The legs were heavy on effort. She was not doing well, and it was good that the diagnosis was made and the therapy instituted.

Chairman Sosman: She also had cold feet. Is that common in coarctation?

Dr. Levine: Yes.

Chairman Sosman: The first patient with coarctation of the aorta I ever recognized was a boy I had seen twice before, and I noticed these peculiar notchings in the ribs. At about that time, a paper was published calling attention to these notchings on the ribs as a sign of coarctation. I got out these films, while I was a medical student at Harvard, and sure enough, he had coarctation of the aorta. So I thought to myself that I would follow that boy because he had twice as much blood going to the brain as to the legs, and I felt that he would be a brilliant and a brainy man. What do you suppose he went into?

Voices: Roentgenology!

Chairman Sosman: He double-crossed me and went into psychiatry. I think he had too much blood that had gone to his brain.

Here is the first chest film on him. I think if you run over it casually, you will see the notches on the ribs. There are three things that we see normally in coarctation; enlargement of the heart and left ventricle; secondly, the lack of the normal aortic arch. She has this flattening above, and that is the collateral circulation, there. This is enlarged, with the lateral circulation around here [showing on film]. And third, there is this notching of the ribs.

The esophagus is displaced a little below where the aorta should be, suggesting aneurysm or coarctation.

The other view here, at the same point we saw these semi-circular points of calcification, and we weren't sure what they were. We got these spot films, and you see that not only one, but two or three are right in there, close together.

I called Dr. Gross, who was scheduled to operate on this patient, and I said I thought she had an aneurysm, with calcification, and that he might have to do an artery graft which was quite rare in those days, in 1949. He said that was a good idea, and that he would wait until he had an aorta in the bank.

Here is the coarctation, there [indicating on film] and the remains of the old patent ductus, and these calcified areas, with these aneurysms, as you see here, and they had to be resected from here to there [indicating on film]. It went off nicely, and she is apparently cured. This is one of the curable heart diseases, as far as I know, which we have seen developed and recognized completely.

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FREEDOM IN MEDICAL PRACTICE*

DWIGHT H. MURRAY, M.D.

The Author. *Dwight H. Murray, M.D., of Napa, California. President, the American Medical Association.*

ALMOST SIX MONTHS have elapsed since we last met to deliberate and act on medical affairs. The time has passed quickly, but not quietly.

The rumble of war and revolution has resounded in our ears. The din from political battles has been deafening.

All of us . . . sooner or later . . . learn that today's events do not just swirl around us, but involve each of us. As doctors we cannot get away from them by claiming that our only interest is in the sick, and that we cannot be bothered by political, social and economic problems. These matters demand attention from the doctor as well as the lawyer, the businessman, the newspaper editor, the labor leader and the worker.

If we are concerned about what happens on the international, national and local fronts—and we should be—then certainly we cannot afford to be disinterested in what happens in our own area of health and medical affairs. Yet there is apathy in our ranks.

* * *

Replace Apathy With Active, United Profession

Today there is a greater need for a united, forceful and informed profession than ever before. We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed.

For example, in a few days Public Law 569, the bill providing medical care for military dependents, becomes effective throughout the land. Contracts already have been signed with the government by the majority of our state societies. No longer can any doctor claim that this law does not affect him. No longer can he say that government laws really are not changing the practice of medicine.

Public Law 880, better known to all of us as H.R. 7225, is another case in point. Medicine now is facing the problem of protecting the taxpaying public from abuses and of cooperating with the government to carry out the provisions of the law. The law is now on the books, and we must provide the leadership necessary to make it work as well as possible.

It was encouraging to hear Ezra Taft Benson, secretary of agriculture, say last week before the American Association of Land Grant Colleges and Universities:

"Sooner or later, the accumulation of power in a central government leads to a loss of freedom. . . . Raids on the federal treasury can be all too readily accomplished by an organized few over the feeble protests of an apathetic majority. With more and more activity centered in the federal government, the relationship between the cost and the benefits of government programs becomes obscure. What follows is the voting of public money without having to accept direct local responsibility for higher taxes . . .

"If the present shift of power from state to federal authority which started 25 years ago is allowed to continue, the states may be left hollow shells."

It was encouraging to hear such comments from a member of the President's Cabinet. I only wish that all members of the official family, and more important, every member of the United States Congress, felt the same way.

The expression of this philosophy, with which medicine so heartily agrees, sounds good, but putting it into practice is the thing we are really interested in.

Today the medical profession along with business and industry is caught between those who desire to promote sound government and those who desire even more intensely to perpetuate party power. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedom. Medicine must do its utmost to reverse this trend.

Medical Freedom Essential

In my travels around the country as your representative the last eighteen months, I have seen

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little dissension or rancor within our ranks. However, I must report that I have seen too much complacency over governmental encroachment into medical affairs. And I am deadly serious when I say to you that apathy by the few, or by the many, can be detrimental to all.

No nation can merely reap the benefits of freedom; it also must sow seeds of freedom.

In medicine the situation is the same. If an apathetic medical profession takes its freedom for granted, it will be the beginning of the end. A strong, free profession must work for freedom so that it may live in freedom. And history tells us that once medicine loses its freedom, other fields of private endeavor are immediately in danger.

I do not wish to paint a dark or distorted picture of medicine's free status and its stature in America today. But I do believe words of caution and an appeal for vigilance are in order.

The road of apathy and disunity can only lead to disorder and perhaps disintegration, and we must sound a warning to all our colleagues who don't care, or who are pulling in the opposite direction. The road of alertness, action and unity is the proper road for all of us to be traveling together.

If I had just one wish for the coming year, it would be to command the time and talents of the 160,000 physicians in the American Medical Association. I would set us all to the task of emphasizing and re-emphasizing the absolute necessity of patient and professional freedom.

Patient's Right to Choose His Doctor

I believe it is one of our prime responsibilities to prove to our patients that their right to choose their doctor is a most important one.

Free choice brings a bond of confidence between doctor and patient which no compulsory medical system can create. It means that the patient knows the physician will be interested in him as a person, not as just a serial number of the 2:45 appendicitis case.

For the doctor free choice means that the patient has selected him for his abilities, training, sincerity and personality. When a patient comes into my office, I know he has made a choice. And from that moment there begins a physician-patient relationship of the highest order. To me the patient is someone special, and I in turn hope I am someone special to him.

Once the patient has made his choice, the physician automatically assumes an unqualified responsibility to the patient. No system of medical care that uses a third party to bring doctor and patient together can match our kind of cooperative performance for the treatment of illness, the cure of disease and the betterment of the patient's health.

Freedom to select a doctor is part of everyone's great freedom to choose—to choose what he wears and eats; where he works and worships, and how he votes. Take away any part of this freedom and great damage is done to our democratic system.

Free Conduct in Medical Treatment

Another freedom closely tied to freedom of choice is freedom in the conduct of medical treatment.

At the recent meeting of the World Medical Association in Havana, Cuba, Doctor Rolf Schloegell of Germany, made a stirring defense of free conduct of medical treatment. He told us that the medical profession believes the attending physician alone is competent to decide what measures he deems necessary and will apply in order to bring about the desired improvement. He warned too of the danger of excessive restriction on the freedom of the patient and the attending doctor.

Yet the trend toward extending social security in the medical care field has been steady and has accelerated since the end of World War II.

The dangers of shifting responsibilities for medical care from the patient and doctor to the government are obvious. The caliber of medical care cannot be as high when both patient and doctor are dependent upon government. Initiative succumbs to dictation, and self-reliance is replaced by the crutch of government.

We do not deny that there is an area of legitimate concern by the government for the health and welfare of the people. But each year government seems to extend that area. We get some idea of this expansion from the new federal medical budget.

This year, according to our Washington Office, the average family will be paying $54.61 for the U. S. Government's health and medical activities. And the total expenditures this year amount to 2½ billion dollars—290 millions more than last year. Even in an over-all federal budget of 61 billion dollars, the total health cost of 2½ billions is not insignificant. It is a billion dollars more than the cost of running the Commerce Department, half a billion more than the Agriculture Department and six times more than the Interior Department's budget.

Many expenditures obviously are necessary to keep up our unsurpassed public health standards, and research may pay rich dividends in scientific discoveries. But there is no doubt that much money is being spent on medical activities that should not involve government participation.

The trend is to spend more and more government money on health and medical matters because it is good politics. Apparently many Americans still want to see government in the role of

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a big brother, dishing out so-called gifts and bargains under the guise of benevolent economic planning.

I believe it is our duty, as it is everyone else's, to combat the attitude of "what's in it for me?" and to promote the long-honored creed of "what's best for all Americans and our free society?" I think that a nation can drift into state medicine inch by inch just as surely as if the scheme were foisted upon a people over night. The "drift" method may take longer but the result will be the same.

So it is time all of us sounded the alarm against soft and superficial security and against the invasion of personal responsibility. It is time we stood up together for militant freedom and for full rights and responsibilities of the individual.

Belgian Doctors Turn Back Government

There is no better example of what a unified medical profession can do than in the story of the recent fight of the Belgian doctors against the government's proposals for a state service of medicine.

Without consulting the medical profession the Belgian government proceeded to draft rules and regulations of health to be incorporated in the nation's social security legislation. Under the proposals, doctors were to sign an agreement to abide by the present rules and any later regulations. For the patient there would be the usual red tape in getting medical care.

When the Belgian doctors learned of the scheme, they met in conference with the government. They told the government what they wanted and what they would not accept. The government agreed.

For several months everything was quiet. Then the Belgian doctors suddenly read about the new health bill that the government was sending to Parliament. It was quite contrary to the earlier agreement worked out by the profession and the government. But the bill was passed quickly.

The Belgian medical profession protested and said it would not be placed under the Ministry of Labor. Instead, the doctors proposed to set up their own plan of medical assistance.

Before long, the government saw that the medical profession meant business and that the doctors' plan was an attractive one. So it declared that its own bill was not in force and could not be in force without the consent of the medical profession.

To me, this fight against legislative intervention in medical care is excellent evidence that the profession can defend itself if it unites to defend the basic principles of freedom and if it offers constructive proposals. By using the Belgian national motto, "in union there is strength," the medical profession showed doctors everywhere that dangerous government plans can be turned aside by the strong.

I also read recently in the Journal of the WORLD MEDICAL ASSOCIATION of the fight of the medical profession of Malta against a British government scheme to introduce a full-time salaried medical service, without the right of private practice, on an island dependency of Malta. Here again the doctors reacted with unity and strength, and successfully thwarted the government's plan.

There is a lesson in these stories from Belgium and Malta. They prove that a unified profession has a great political power for good—the good of the patient, the doctors and the nation.

Confidence and Understanding Needed

While we are developing unity within our own ranks, I believe it is equally important to continue to build up the confidence and respect of our patients and to make our legislators aware of the necessity for freedom in medical practice.

Let us never reduce the quality of service we render to our patients, and never lose the personal touch in medicine. Where there is any opportunity to improve upon our medical care, let us seize it and show our abilities to do an outstanding job. Satisfied patient-customers will give us deserving support when we need it.

We also should realize that the destiny of medicine can be determined to a large degree in the halls of Congress. If this be true, then it is even more important that we take an even greater interest in those who elect the Congressmen. Sympathetic understanding of our position by federal legislators through the voting public will be an insurmountable deterrent to the forces supporting state medicine.

The day has come, gentlemen, when we can no longer look upon medical economics and social changes merely as issues to be considered during our limited leisure hours. Our interest in them cannot be superficial or intermittent.

We now must pay daily attention to these matters. Medical socio-economic affairs can no longer be just incidental with us. They must be a vital part of our life and of our profession.

Each of us, I believe, should dedicate himself to the words included in the oath of office taken by presidents of the A.M.A.

"I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans."

As doctors, representatives to the A.M.A. and as spokesmen for the A.M.A., let's remember these words and live by them. And to alter a phrase of President Lincoln's only slightly: Let's make common cause to keep the good ship of medical freedom on this voyage, or nobody will have a chance to pilot her on another voyage.

CHRONIC ADRENAL INSUFFICIENCY AND FATAL ANAPHYLACTOID TRANSFUSION REACTION

MICHAEL G. PIERIK, M.D., AND TARAS HANUSHEVSKY, M.D.

The Authors. *Michael G. Pierik, M.D. and Taras Hanushevsky, M.D., Attending Physicians, Department of Medicine, Our Lady of Fatima Hospital, North Providence, Rhode Island.*

AMONG the well-known complications of long-term adrenal steroid therapy is the relative inability to withstand surgical stress once hormones have been discontinued; hence it has become axiomatic that such therapy must be continued throughout the operative period, even in the face of such emergencies as perforated or bleeding peptic ulcers. The following case indicates that apparently minor stresses must be handled as cautiously.

J. M., a fifteen-year-old white female, was admitted to Our Lady of Fatima Hospital on March 7, 1956 for rehabilitation. Patient had suffered from ankylosing rheumatoid arthritis for the past five years. Several forms of adrenal steroids had been given nearly continuously over the past four years. This had relieved pain to a great extent but knee deformities had progressed, limiting patient to a bed and wheel-chair existence. Further, *moon facies,* lethargy and a depressive type of personality change had appeared. These had blocked efforts to ambulate the patient.

There was no past history of atopy, hay fever or allergic drug reaction. Physical examination revealed an anxious, depressed, lethargic, white female. In addition to typical rheumatoid deformities of the hands and knees, there was pronounced facial and ankle edema. No cardiac abnormalities were found. Blood pressure was 130/80.

Laboratory studies revealed hemoglobin of 9 grams, RBC 3.59 million, corrected sedimentation rate of 30 mm. per hour (Wintrobe). Total circulating eosinophiles were 600. Two weeks prior to death, intramuscular ACTH produced a four-hour fall in eosinophiles to a level of 100. Urinalysis, serum proteins, A:G ratio, sodium chloride, potassium and B.U.N. were normal. X rays of the knees revealed rheumatoid changes but with preservation of some joint space. Skull X rays were negative.

Course

Patient was believed to be a good candidate for at least partial ambulation. In order to accomplish this, it was considered mandatory to wean her from steroids. Gradual reduction in prednisone was accomplished over a three-week period. No ill effects were noted. A twelve-pound weight loss and marked improvement in spirits ensued. Under intensive physical therapy patient ambulated with crutches for the first time. As hemoglobin remained at a level of 9 grams, a supportive whole blood transfusion of 500 cc of Group A, Rh positive blood was given on the fourteenth day following cessation of all corticosteroid therapy.

Fifteen minutes after commencement of transfusion, a typical anaphylactic reaction occurred with temperature spiking to 101° and shaking chill. No urticaria, pulmonary edema or fall in blood pressure was noted. Symptoms abated and temperature fell to normal after prompt discontinuance of transfusion. Careful re-check indicated complete compatibility of blood. A catheterized specimen revealed no hemoglobinuria. Patient's condition remained satisfactory with stable temperature, pulse and blood pressure; however, about three hours later there was gradual onset of cyanosis and fall in blood pressure to 60/0 with increasing signs of pulmonary edema. Repeat urinalysis was normal and output remained adequate. Cultures from patient's and donor's blood were subsequently sterile. Prompt therapy of parenteral digitalization, intravenous hydrocortisone, nor-epinephrine and nasal oxygen was unavailing. The patient expired in pulmonary edema eight hours after the onset of the reaction.

At autopsy, besides obvious rheumatoid deformities and facial edema, the gross pathological findings were limited to bilateral pulmonary edema and splenic and hepatic congestion. Microscopic study of adrenals revealed conspicuous atrophy of the zona fasciculata and impregnation of the zona glomerulosa with Sudan-positive lipoid globules. Slight zonal metamorphosis of the liver cells was present. There was no evidence of cardiac disease or pulmonary embolism and renal structure was well maintained.

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Final pathological diagnoses were:

(1) Chronic rheumatoid arthritis.

(2) Acute anaphylactoid pulmonary edema.

(3) Atrophy of zona fasciculata and lipoid infiltration of the zona glomerulosa of the adrenals.

Comment

It would seem that hazards of interrupting steroid therapy prior to major surgery are also present in procedures where danger of anaphylaxis or unusual physical stress exist. Examples would be transfusion or electroshock therapy. It is suggested that more careful assessment of adrenal function be made in such patients. The effect of a test dose of fluorohydrocortisone or intravenous ACTH on urinary 17-ketosteroid excretion should be of value.[1] Conventional tests did not reveal the severity of adrenocortical derangement in our case. Poor adrenal response is an indication for continuance of steroids throughout such procedures. If such therapy has recently been interrupted, prophylactic coverage of a transfusion by intravenous cortisone may be life saving. The delay of several hours before onset of collapse in the above patient led to a false sense of security and probably rendered supportive treatment unavailing.

SUMMARY

An apparently mild anaphylactoid transfusion reaction terminated fatally in a case of chronic adrenal insufficiency. More careful assessment of adrenal function or continuance of steroid therapy in such patients is indicated.

[1]Thorn, George W.; Forsham, Peter H.; Frawley, Thomas F.; Wilson, Laurence D.; Renold, Albert E.; Frederickson, Donald S., and Jenkins, Dalton: Advances in the Diagnosis and Treatment of Adrenal Insufficiency. J.A.M.A. 10:595-611, 1951

A BRIGHAM X-RAY CONFERENCE

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Dr. Levine: She has done well, with an excellent result. The pressure of the legs is now higher than in the arms, and the arms are normal. She had one of those perfect results that are found now and then, and now it has been for some years.

I should have added that clinically these patients frequently have pulsating arteries, below the scapulae, around the back.

Chairman Sosman: Are there any further questions?

Question: Would you mind discussing pregnancy in relation to coarctation? If they came in to you before they were pregnant, would you tell them? At two and a half months or so what would you do about it?

Dr. Levine: I will base my discussion on the little bit I have read, and one experience. The experience that I had was a sad one. There is something about pregnancy that renders these patients a little more likely to rupture.

I had the unhappy experience of seeing one who had ruptured during the early pregnancy, and she died in the customary fashion, in severe pain, and a couple of days later ruptured into the pericardium.

I don't know what the statistical incidents of rupture would be in a group of pregnant women with coarctation. It would be awful enough, even to want to interrupt or avoid pregnancy until the coarctation is cured. I think, as of the present moment, that if I had to make a diagnosis of pregnancy and coarctation, I would advise surgery right there, because of this one unhappy experience.

Chairman Sosman: This has been repeated in other places.

Dr. Levine: There is something about pregnancy that does it.

Question: How early in life do you see coarctation?

Chairman Sosman: You rarely see it under twelve; from twelve to fifteen it begins to show up, in practically all of the cases.

Question: Would you regard the notching as pathognomonic?

Chairman Sosman: It is almost pathognomonic. I saw it in one case of arteriovenous aneurysm in the lung, and the blood supply came in from cross arteries, and the notching was tremendous. Another case was due to fibromatomas. These neurofibromas were causing the notches. Those were both unilateral and the coarctation is almost always by lateral notches.

Question: Can you have coarctation without the notching?

Chairman Sosman: Oh, yes; you can have coarctation without notching, and particularly in young children.

Question: Is the blood pressure the same on both sides?

Chairman Sosman: As a rule, in this type of coarctation, it is equal in both arms. There are some where the coarctation occurs in the arch of the aorta and you have hypertension of the right side, and it is normal or low in the left side, and that is bad.

Question: How about the leg blood pressure?

Chairman Sosman: It would be lower. We found one at the twelfth thoracic vertebra. But, most of them are right below the arch, where the ductus arteriosus originates or enters.

Question: How about the age of the patients?

Chairman Sosman: At what age is Dr. Gross operating now, Doctor?

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PRAISE OF THE PLACEBO

WHAT is the placebo? Are physicians justified in prescribing it? If so, why, when and for whom? In the recent past these questions have engaged the attention of several physicians and the READERS' DIGEST has brought them to the attention of the public. The placebo is not new; the old-time physicians were well acquainted with it and frequently employed it; one of them said that it was given *ut aliquid fieri videtur*—that something might seem to be done. About ten years ago Doctor C. H. Perry Pepper pointed out that there had been, up to that time, no published paper which discussed the important subject of the placebo. No mention of it was to be found in the Index of the Surgeon General's Library nor in the Cumulative Index. It is not to be found in LaWall's interesting book, TWO THOUSAND YEARS OF PHARMACY. Modern books on treatment—Barr, Beckman, Clendening—ignore it. But the contemporary climate of medical opinion is changing, thanks, no doubt, to the progress and the wider diffusion of psychological medicine; so that at present the placebo is regarded, if not indeed with admiration, nevertheless with something approaching respect.

Placebo is, of course, the Latin verb which means "I will please," and the dictionary says it is a "Medicine given merely to please the patient." Now, to some of us, this appears to be an unsatisfactory definition based upon the uncriticized assumption that its pharmacological action is the only valuable function of a drug; for, if one reflects a little, it should be obvious that every drug, however potent pharmacologically, has about it always an aura of what one may call placeboism. Hence, should we not say that we are in error when we describe the placebo as medicine's "humble humbug?" For who will deny that if we remove the placebo's nimbus from our medical armamentarium we shall be poor indeed. Veterinary physicians may get along well enough without the placebo, but human nature being what it is, our patients will always accept our ministrations tinctured with faith and hopeful expectation.

This is perhaps the reason why the most effective placebo is not a drug or a piece of imposing apparatus, but the physician himself. This also is the reason why the first step in the art, as distinguished from the science of diagnosis, is not a step at all; the first step in diagnosis is to sit and listen. How

continued on next page

much less effective would be our vitamins, estrogens, tranquilizers and hypodermics did they fail to impress and please their recipients. Since then, we cannot if we would, banish the placebo, let us accept it gratefully and prescribe it when advisable, not timidly but with that confident persuasiveness which enhances its value. To prescribe a placebo with hesitancy and a sense of guilt is to rob it of its power for good. The placebo is not, therefore, a "humble humbug"; on the contrary, it is an important ingredient in the art of healing.

To support these somewhat cursory remarks with evidence, it is interesting to mention only one of several recent studies of the placebo. Doctor Henry K. Beecher describes what he calls *The Powerful Placebo* in a contribution from the Anesthesia Laboratory of the Harvard Medical School at the Massachusetts General Hospital (Journal, A.M.A., December 24, 1955). Summarizing his findings based upon much careful research and a critical evaluation of his results, Doctor Beecher concludes, "It is evident that placebos have a high degree of therapeutic effectiveness in treating subjective responses. This is shown in over a thousand patients in fifteen studies covering a wide variety of areas: wound pain, the pain of angina pectoris, headache, nausea, phenomena related to cough and to drug induced mood changes, anxiety and tension and finally the common cold—a widespread collection of human ailments where subjective factors enter." It would appear then that the placebo, once a mere Cinderella, is acquiring clinical respectability as, when wisely chosen, a useful therapeutic agent.

THE MOTOR VEHICLE OPERATOR'S LICENSE

The Medical Advisory Committee to the Motor Vehicle Department of the State of Rhode Island has been meeting once monthly. So far the chief business has been to decide whether citizens who are disabled or who have suffered from mental or physical disability are fit to operate motor vehicles with safety to themselves and to other drivers and pedestrians. The majority of the disabilities are caused by mental disorders such as psychoses, epilepsy or alcoholism, and general diseases such as diabetes and cardiovascular lesions involving the heart and brain. Thus far two major problems have been presented.

The first is that there are no universally accepted norms as to what constitutes recovery and what constitutes dangerous disability. Doctor Arthur E. O'Dea, Chief Medical Examiner for the State of Rhode Island and Chairman of this Committee, has long been interested in and has had considerable experience with these problems. His group is confident that practical and workable standards can be drawn up which may be universally accepted and applied. Much work is ahead but the results will be rewarding.

Secondly, it has been noted that in the past physicians' letters have not been specific enough concerning the physical and mental status of the person applying for his motor-vehicle license. The Committee believes it is not enough to state that "In my opinion John Jones is capable of driving a motor vehicle." The letter, in addition, should state the dates of illness or injury, the treatment, and the specific diagnosis in the standard nomenclature of disease. The type of treatment should be specified and the amount and kind of medication. One of the most important points is the physician's opinion as to the prognosis. For example, a *nervous condition* is not sufficient as a diagnosis; the kind of nervous condition—e.g., paranoid schizophrenia—should be stated. Also, *symptomatic treatment* is not sufficient; the kind and dosage of medication should be stated—e.g. in the case of a diabetic, NPH Insulin forty units daily before breakfast. If the doctor's letter is not specific, then the applicant's application will be put aside until complete information is forthcoming.

If the Rhode Island Medical Society, through this Committee, is responsible for the certification of these applications, the individual physician also is directly responsible to his patient, to the Society, and to the public when he signs the letter for or against an application for a motor-vehicle operator's license.

BUTLER HOSPITAL AND DOCTOR HYDE

The decision to reopen Butler Hospital has been received by the people of Rhode Island with real satisfaction. There is a general sense of gratitude to all who have worked to clear the way for the making of this decision, and especially to the present Board of Trustees, who have carried out careful studies which have led to this result. Certainly, the detailed and extensive survey made by Doctor Blain, of The American Psychiatric Association, involving, as it did, the cooperation of experts invited to come to Rhode Island to participate, and of representative citizens from within the state, resulted in a clear understanding of the situation by the Trustees, which has led to their action.

Now they have chosen the new skipper of the craft that they have decided to put into commission and launch in the immediate future. The Journal believes that the choice is a happy one. Doctor Robert W. Hyde, the newly appointed superintendent, possesses the qualifications that will render him very well suited to a task of such great importance to this community and to New

England. A Vermonter by birth, and a graduate of the Medical School of the University of Vermont (*cum laude*) in 1935, Doctor Hyde has had a broad experience both in general medicine and psychiatry. After his internship at New Orleans, he followed a course which can well be recommended to all who plan to specialize; that is, he practiced general medicine in a small town. Then, following five years in the Army, he went into psychiatry and has served since 1945 as assistant superintendent at the Massachusetts Health Center (Boston Psychopathic Hospital).

He is certified by The American Board of Psychiatry and Neurology; a Fellow of The American Psychiatric Association; a Certified Mental Hospital Administrator and a member of the A.M.A.; Massachusetts Medical Society; Society for Research in Psychiatry; Massachusetts Psychiatric Society and the Group for the Advancement of Psychiatry. He holds teaching positions in both Harvard Medical School and Boston University, and has held a number of positions on committees and Boards in Massachusetts, including the Board of Directors of the Massachusetts Tuberculosis and Health League. He is also a Sponsoring Member of the National Mental Health Committee.

His personal bibliography includes fifty-six scientific papers in his field and other publications, including collaboration in the preparation of *From Custodial to Therapeutic Patient Care in Mental Hospitals,* published by the Russell Sage Foundation.

It is understood that Doctor Hyde, after completing his teaching and other assignments in Boston, and visiting mental hospitals in various parts of the country, will take up his duties at Butler Hospital during the month of February. On the basis of our knowledge of the universal interest that has been shown by the public and the medical profession in the reopening of Butler Hospital as a Mental Health Center, it is possible to assure Doctor Hyde that he will have maximum support in his endeavors to make this well-beloved institution a Mental Health Center that will, in the value of its service to the public, exceed its great achievements of the past. It is a privilege to welcome this distinguished colleague to Rhode Island.

THE EROSION OF MEDICAL LIBERTIES

"Today there is greater need for a united, forceful and informed profession than ever before. We have been caught in the throes of a social revolution which demanded something for nothing. Changes have been taking place all around us, and medicine has not escaped unscathed."

—DWIGHT H. MURRAY, M.D., *President* of the American Medical Association, in his address to the A.M.A. House of Delegates at Seattle, Washington, Nov. 27, 1956

TEN DAYS after Doctor Murray sounded his warning to the leaders of American medicine the federal government put into operation its program providing medical care for dependents of the armed forces, now popularly known as the *Medicare* plan. Was the medical profession well informed of the program? Was it united? Did it take forceful action?

There are many who would answer these questions in the affirmative, and promptly. We would qualify our replies, based only on our Rhode Island experience.

We were informed of the legislation by the Washington Office of the A.M.A., as was every other medical society. We recognized the emotional and political appeal of the legislation. We also recognized the fact that medicine would not, as Doctor Murray says, "escape unscathed." We were informed, as were the other states, *that considerable discretionary power would be given under the program to the executive agencies that would carry it out.*

From the debate on the bill before the House we learned that Representative Kilday had said

> **"When we start on a new program of any kind which grants benefits to individuals we must bear in mind that we can never thereafter for practical purposes decrease the benefits granted. Once we grant a benefit, it is going to have to be constant. We can always expand benefits . . ."**

and in the Senate debate we learned that Senator Stennis stated

> **"It is my opinion that within the bill there is the framework of what could lead to the socializing of the great medical profession. I emphasize 'could lead' to that. I do not believe the bill is intended to, or if soundly administered, will lead to that, or that the bill is a step in that direction. Nevertheless, it creates, as I see it, some possibilities which could be used as a leap in the direction of socialized medicine."**

and Senator Russell was reported as stating

> **"If the proposed law is administered as it has been outlined to us it will be, it cannot lead to socialized medicine any more than the Blue Cross or Blue Shield does; but I must say there are some elements of discretion which if improperly exercised might point in that direction."**

With all deference to Senator Russell we fail to see any valid comparison between a compulsory tax-supported medical care program of the federal government for the dependents of the armed services and the free choice, voluntary-supported Blue

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Cross-Blue Shield plans. The government plan is already a form of socialized medicine; the voluntary programs definitely are not.

Senator Russell made his comment on the floor of the Senate on May 14. The Senate-House Conference Report on the bill, issued May 22, offers an interesting observation on the future expansion of this legislation by which the freedom of the individual to seek and to pay for his own medical care, and the right of the physician to render the care and be paid his fair fee for service, would be further curtailed. In the Conference Report appears the following:

> **"The House bill granted the Secretary of Defense discretionary authority to contract for an insurance, medical service, or health plan or plans to provide medical care for *retired members of a uniformed service as well as their dependents and all other dependents other than spouses and children* (italics ours). The Senate amendment contained no such language. The House managers agreed to the exclusion of this discretionary authority with the knowledge that after the . . . plan or plans has been in operation for spouses and children for a period of time *it may be possible to later extend the law to the other groups that would have been included under the House bill* (italics ours). . . . It is obvious that the program cannot be extended to retired members and other groups until at least a cost and experience level has been obtained as a result of the program which is to be placed in operation. . . ."**

Yes, we were all informed of the implications of the legislation. Did we unite for forceful action against the growing control of the administrative process over the rights, freedom and welfare of the individual citizen? We did not. Instead, each state medical association answered an individual summons to Washington, there to meet in private with federal "negotiating teams" who had their plans already drawn, and who only sought to have the states aquiesce to the arrangements. If this was to be the exercise of free action at the local level we, at least, were not deceived.

Even in our compact New England area with trading centers bringing people across state lines continuously, there was no conference to consider the regional influences, nor did the federal planners allow any of our representatives to meet jointly on the occasion of "negotiating conferences" in the Navy building in Washington. On the occasion of the visit of the Rhode Island delegation the negotiating team submitted on that day a new contract—not previously submitted to our legal counsel at home—a new joint directive, and its own version of prevailing fees for our area, and then asked that the contract be signed on that or the following day!

Could this be one of the elements of discretion for which Senators Russell and Stennis expressed concern in the debate on the legislation?

Because Rhode Island did not "negotiate" on the terms of the Department of Defense no contract was subsequently submitted to the Society. Nevertheless the Society will give its assistance to the program by publicizing it to its membership, by issuing claim forms for the government agency, and in general by guaranteeing that armed service dependents, as all citizens and residents of this State of Rhode Island, shall be given the best available medical care for which the fees will be consistent with the fair, reasonable and prevailing charges made to everyone in this area.

We resent creeping *authoritarianism* in any form. Rhode Island was conceived as a colony on the basis that a most flourishing civil state may stand and best be maintained with full liberty in religious concernments. Rhode Island was two months ahead of the other colonies in making its Declaration of Independence from King George III, on May 4, 1776. We were the last to ratify the United States Constitution, and 127 years later the state refused to ratify the 18th amendment.

With such a heritage we make no apology when we take our stand firmly as we see individual rights progressively subjected to more or less arbitrary governmental controls.

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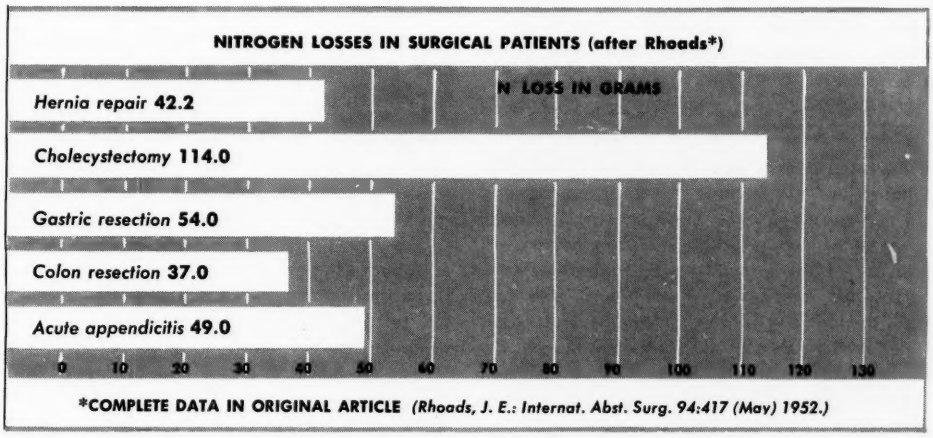

Patients about to undergo extensive surgery[1] frequently have negative nitrogen balance and protein deficiency. And after any severe trauma, including extensive surgery, the rate of protein breakdown is increased.

It is also well recognized that patients with a strongly negative nitrogen balance are much more prone to suffer delayed wound healing[2], secondary infections[3], shock[2] and delayed convalescence[4].

The need for an effective protein anabolic agent is stated by Moore and Ball[5]—"there is one unbreakable rule of surgical convalescence: to complete his recovery, regain strength and return to work the patient *must* come into positive nitrogen balance."

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The daily adult dose is three to five Nilevar tablets (30 to 50 mg.). For children the daily dosage is 1 to 1.5 mg. per kilogram of body weight for the first ten days of treatment, after which the daily dosage should be reduced in all prepuberal patients to 0.5 mg. per kilogram of body weight. Individual dosages depend on the need for and the response to therapy. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine. References supplied on request.

SEARLE

WORKERS IN WHEELCHAIRS*

HENRY VISCARDI, JR., LL.D.

The Author. *Henry Viscardi, Jr., LL.D., of West Hempstead, New York. President, Abilities, Inc.; President, and Board Chairman of Human Resources Corp.; Executive Vice President and Board Member of Just One Break Inc.; member of faculty, New York University College of Medicine; member, National Advisory Council of Department of Health, Education and Welfare, Division of Vocational Rehabilitation; recipient of Presidential Citation for Outstanding Work in the Employment of the Physically Handicapped.*

THE ESTIMATES now run as high as 33,000,000 people in our nation who are disabled, chronically ill, or over-age. My friends, this is about one in seven of our population. The progression is increasing. They now estimate that in a brief fifty years, for every one of us who works and produces, we will be carrying on our backs to support, one individual who falls into this category.

From a moral or an economic viewpoint, I ask you, can we afford it? Let me give you some strong reasons about why I think we cannot.

The tragedy of our times is that we have succeeded in splitting the atom before acquiring the wisdom to unite mankind. Our major need today is not for more knowledge as to how to fly through the stratosphere, but for understanding of how to walk upon the face of the earth like human beings created in the image of God.

Not more science do we require, but more of the milk of human kindness. Not more bombs to destroy, should be our aim, but more of the balm of healing and building up the wounds of mankind fallen into disunity.

Not more *know-how* but more *know-why*. Not more *knowledge* is our greatest need, but more *wisdom*.

Because there is a labor shortage now in many parts of our country, we have understanding about the problem that is the commodity of expediency. Do we really understand?

What is a physical handicap? We tend to believe that a physical handicap is not a physical handicap when it doesn't interfere with our occupations; that it is, when it prevents us from performing the task of a specific occupation.

This is wrong, my friends. A physical handicap refers to human limitations, from the medical point of view, and whether the disability stems from disease, injury, or inheritance, makes no difference.

An occupational handicap refers to the lack of ability to perform all of the specific tasks for a specific occupation. These can be skill, experience, aptitude, interest, personality; and only one among these is the physical capacity to do that job.

If any of the skills are lacking, the person is occupationally handicapped for the specific job to be done. The fact is, that a physical handicap remains a physical handicap, whether or not the disabled person is occupationally handicapped.

The blind men in my plant are not occupationally handicapped, because they are successful at their jobs or they wouldn't be there. But successful or not, they remain physically handicapped because they are blind.

The challenge for all of us is to recognize that the amputee, or any other disabled person, is not different from the rest of the world. The difference is only in degree of ability, like being fat or thin, tall or short. The amputee is the same in thousands of ways, more than he is different. In society and in industry, he wants to be considered so.

What about our psychological reactions to disability? Almost everyone likes to feel superior in one way or another. On the basis of sheer physical differences, the normal person rarely fails to sense that he is better than the disabled.

Much of this feeling is released because of our perfectionist ideals. We have the Hollywood concept of the girl we would like to marry. Who has not had daydreams about how wonderful it would be to be physically perfect, perhaps like a Greek god?

Almost everyone admires a good physique. At least let us admit that no ordinary person admires deformity. Ancient aversions are still aflame in modern man.

The idea that the crippled are in some way connected with sin and evil, allows the able-bodied person to feel he is morally better. He is assured of his moral superiority since he thinks nothing so terrible has happened to me, thank God.

The sense of superiority, and the aversions are

*Part of an address delivered at the Interim Meeting of the Rhode Island Medical Society, at Providence, Rhode Island, October 24, 1956.

so strong in some able-bodied persons, that they go so far as to link disability with insanity. One does not have to seek far to find those who are so fearful of spastics and epileptics, or even of less severely handicapped persons, that they avoid them like the plague.

The sad fact is, my friends, to state it mildly, the disabled are thought to be different, not only physically but in general. They are considered to be not so good as others.

Socially, they are usually the last accepted. Industrially, they are often the last to be hired and the first to be fired.

How to overcome our superstitions and backward psychological reactions towards disability, is clearly a problem that we must face.

Physical differences in human beings have always produced deep psychological reactions. Our reactions to disability have never been pleasant. Throughout the ages, disability has been associated with evil, never with good.

I grant you the attitude of modern man is changing, with the incidence of two great wars, and the disabled men who came home, plus the modern automobile through which in a brief fifty years we have killed and maimed more people on the highways of our country than were disabled or killed in 175 years of our nation's wars.

How much have our attitudes really changed? It cannot be denied that we harbor many Philistine thoughts and taboos concerning disabilities. These thoughts are highly subjective. They are not frequently discussed. They are not clear-cut. They vary in intensity. They are difficult to describe, and worse still, they are even more difficult for one to admit honestly.

Our natural reaction to idiots is so horrifying, that by thinking of them as God's children, we succeed in changing a shocking situation into one less distressing to us. We, our selfish selves, are thus relieved to a degree.

Rather than being shocked by disability, it is easier on us if we are sympathetic and tolerant. Sympathy allows us to overcome some of our feelings of guilt for looking askance at the disabled.

If we are deeply honest with ourselves, we can realize that our sympathy is but a pleasant compensation for more complex feelings of fear and revulsion.

If we were truthful with ourselves, we would likely feel neither revulsion nor sympathy. We would look upon all persons as human beings, or perhaps it may be said, upon all persons as being truly God's children.

If we were balanced, we would most certainly not divide humanity into the blessed and the damned.

The Lord said,
"Say, 'We' ";
But I shook my head,
Hid my hands tight behind my back, and said,
Stubbornly,
"I."

The Lord said,
"Say, 'We' ";
But I looked upon them, grimy and all awry.
Myself in all those twisted shapes? Ah, no!
Distastefully I turned my head away,
Persisting,
"They."

The Lord said,
"Say, 'We' ";
And I
At last
Richer by a hoard
Of years
And Tears,
Looked in their eyes and found the heavy word
That bent my neck and bowed my head;
"We,"
Lord.

Abilities Vital Factor

How do the disabled differ from other people? Is society to be divided into sheep and goats, superior and inferior people? Both the physically impaired and the unimpaired are the same in thousands of ways, more than they are different.

Disability is measured from a medical point of view. But whether the physician finds things wrong with people or not, the awful truth is that the so-called disabled and the so-called physically fit, are both physically handicapped.

Like the disabled, the physically fit person is always physically limited for numerous occupations and activity in life. On a sheer physical basis, practically every human being is physically limited in one way or another, in an industrial sense. And when you add to this, intelligence, the emotional and psychological factors, clearly every one of us has great limitations, physically fit or not.

It certainly has taken us a long time, to discover that human beings are only human beings, and not sheep and goats; that all persons have multiple limitations, physically, emotionally, and intellectually.

It is unlikely that the key to the whole problem of disability, can be found in a simple reversal of our philosophy, but rather than thinking longer in terms of disabilities, we might well start thinking of abilities, instead.

Outside of medicine, and in society at large, everyone including the doctors, might very well

continued on next page

be educated to think of the abilities of people, what they can do, and not their disabilities.

For we who are laymen, enlightenment will not come so long as we continue to use the negative terms and stress disabilities. The negative implications in the terms used by medicine—epileptic, tuberculous, paraplegic—excite superstition, stigmatize the disabled, and tend to segregate the disabled into an inferior group.

Outside of professional medical and rehabilitation circles, we should not use these negative labels; not even the word "handicapped," "impaired," or "disabled." We have the perfect terms now. The only correct terms *men* and *women, boys* and *girls, children.*

We should look upon these men and women and children as human beings like ourselves, and should think and speak of their abilities and not their disabilities.

Our disabled people are crying for this right to be the same. They both want to be, and should be, considered as the ordinary people they really are, each according to his individual capacities and ability; each with his compensating qualities to offset the extremes of physical make-up is the same as everyone else in the world. No one—none of us—is without limitations, and when we consider the requirements of many specific jobs we are all disabled.

What is needed, and gradually we are coming to realize it, is the denial of the common assumption of the distinction of disability. There is really no such thing. Sheer physical strength is no measure of general ability. Many factors go to make up a total personality, some of which in this enlightened age are far more important than physical strength or weakness.

Homer could have squatted in the dust at the gates of Athens; the rich would have pitied him, and tossed gold into his cap. For he, like Milton, and Prescott, the historian, was blind.

Julius Caesar, the first general, statesman, and historian of his age, and excepting Cicero, its greatest orator, a mathematician, jurist, and architect, he was an epileptic.

Beethoven, the ultimate genius of the classical schools of music, beyond whose creations, as Wagner said, instrumental music can never go, became stone deaf before middle age, and never heard except by the inward ear, his own great symphonies.

There are no disabled veterans; they are only veterans. There are no disabled people; only people. The greatest complement for the extreme of physical suffering, is the patience to continue to struggle for the right to be the same; not different from the rest of the world.

There is nothing that can be substituted for this basic human right; no honors, no pensions, no parades, or subsidies replace the wish of every person who has known disability, to live and work in dignity, in free and open competition with all the world.

On one day perhaps we will have an end to all the special privileges of being different, and be allowed the equal opportunities and challenges of being the same as the rest of the world.

There is no substitute for the sweet dignity of a productive life. It is essential to the American tradition, founded deep in the roots of Western civilization.

The hinge of fate has made this nation a leader in the struggle for the oppressed, wherever darkness has fallen and the light of liberty has gone out.

If the coming generation of Americans is to be predominantly the disabled and the over-age, then it is our destiny so to live and so to perform our part, that free men across the years will look back and say, "Here was a generation that did not seek security, but looked for opportunity."

Why Me?

I grew up as a crippled child, horribly deformed. I spent the first seven consecutive years of my life in one hospital. When I was a child, I remember my mother's explanation when I asked her "Why me? Why me?"

She told me that when it was time for another crippled boy to be born into the world, the Lord and His counsellors held a meeting to decide where he should be sent, and the Lord said, "I think that the Viscardis would be a good family for a crippled boy."

That is the way I feel about our country, about the communities, about commerce and labor and industry. If this, the greatest industrial nation in the history of the world, is increasing its population of disabled and over-age people because of its progress, then no better laboratory could have been selected to provide a pattern for the utilization of our priceless human resources.

I asked God for Strength, that I might achieve,

I was made weak, that I might learn humbly to obey . . .

I asked for health, that I might do greater things,

I was given infirmity, that I might do better things . . .

I asked for riches, that I might be happy,

I was given poverty that I might be wise . . .

I asked for power, that I might have the praise of men,

continued on page 44

New – A Faster-Acting More Effective Spasmolytic

In a series of 120 patients with diverse complaints such as gas, bloating, nausea, cramps, etc. referable to the g.i. tract, Olson[1] obtained "rapid symptomatic relief" in 92 cases with COACTYN, *a new pH-adjusted phosphorated carbohydrate solution containing homatropine methylbromide and phenobarbital.*

Significantly, in those cases which were *functional* in nature, the relief obtained was "more satisfactory than with usual antispasmodic or anticholinergic medications."

AND

"When Coactyn did not afford relief from symptoms, further diagnostic procedures in most instances revealed organic lesions of the g.i. tract."

ABSTRACT OF CASE REPORT

A 42-year-old white female complained of severe gas and bloating after eating "almost anything." She had had a cholecystectomy. Abdominal distention was so marked as to raise the question of pregnancy. Cramping became so severe that parenteral anticholinergics were sometimes required, with but partial relief. A g.i. series revealed only hypermotility and spasticity of the entire g.i. tract. Among the drugs which had been tried were estrogens, sedatives, almost all of the available antispasmodics, and numerous alkaline buffering agents. None gave satisfactory relief. Administration of COACTYN resulted in "almost complete alleviation of symptoms." The patient was able to tolerate a better balanced diet. The author calls attention to the "topical" antispasmodic effect of the pH-adjusted phosphorated carbohydrate solution.

FORMULA:

Each teaspoonful contains 0.5 mg. homatropine methylbromide and 8 mg. phenobarbital in a phosphorated carbohydrate solution with the pH of the entire preparation adjusted at an optimally effective level. Alcohol 9.5%. Pleasantly apricot-flavored.

DOSAGE:

1 or 2 teaspoonfuls, *undiluted*, 15 minutes before meals; additional doses if necessary.

SUPPLIED:

Bottles of 3 fl.oz. and 16 fl.oz.

1. Olson, J. A.: Am. J. Digest. Dis., Nov., 1955.

Coactyn TRADEMARK

Kinney **KINNEY & COMPANY, INC., Columbus, Indiana**

WORKERS IN WHEELCHAIRS

continued from page 42

I was given weakness, that I might feel the need of God . . .

I asked for all things, that I might enjoy life,

I was given life, that I might enjoy all things . . .

I got nothing that I asked for—but everything I had hoped for,

Almost despite myself, my unspoken prayers were answered,

I am among all men, most richly blessed.

Record of Abilities, Inc.

Now let me tell you a word more about Abilities, Inc. and its people. I have told you that when I left today, I left 326 working men and women in our factory. Would you be interested to know that on the basis of our rated experience over four years, from the standpoint of compensation and liability, our little company has had such a successful record that in 1954 we were downrated 21 per cent, and in 1955 we were downrated 27 per cent? We have had but two reportable accidents in four years, and these were insignificant.

Would you be interested to know that the average day's absence per 100 scheduled working days in industry, is 3.3, but at Abilities, Inc. it is .88?

Would you be interested to know that the average day's loss per injury in American industry for 100 scheduled working days, is 1.3, and in Abilities, Inc. it is .01?

Could I tell you that the days of disability for injury in the average American company is 14.3, and at Abilities, Inc. it is 3.1?

Might I mention that in four years of productive work, these people who have been in our company have produced goods valued at $2,401,700? They have earned wages of $1,279,100? The total of new wealth which they have turned back to the community and to the government in taxes, wages, and goods produced, in four years, is $4,686,490?

During this same four-year period, it would have cost $740,000 to have maintained these people on the relief rolls. Not only have we saved $740,000, but we have added approximately $4,700,000 in new wealth.

Can you help me calculate the intrinsic worth of what we have bought in dignity and happiness for each of these people and their families, who have now known the dignity of a productive life instead of a life predicated on the charity of the community or the family?

There are today, my friends, many who believe the answer lies in some form of government agency or authority. It is not so. It is not so. This

great country of ours was founded community by community. It grew, community by community.

Our Constitution was born expressly to provide a government and propagate a nation of self-governing communities; to delegate that authority necessary to accomplish jointly what the home town could not do for itself.

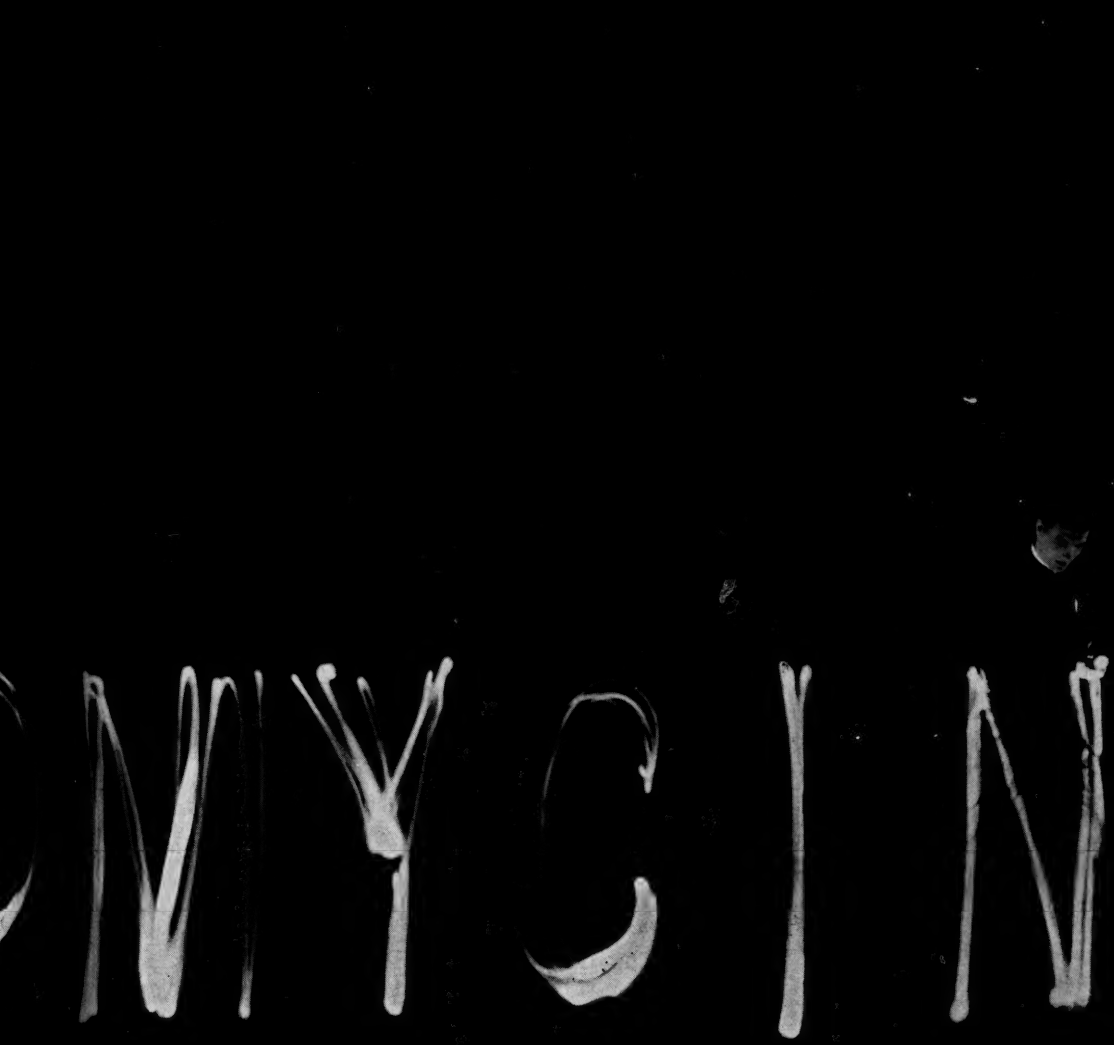
Nothing, my friends, nothing—including a lot of talk about the welfare state, has changed these fundamentals. It is on your level and mine that long-range solutions can be found for our disabled and over-age people.

Believe me, there are no bargains in security, not only for our disabled citizens but for all of us. The price of just a little bit of federalized security, comes exceedingly high, and the cost of totalitarian security is so great that no nation or people in history has ever been able to afford it.

I leave with you tonight, the credo of Abilities, Inc., defiantly adopted four years ago when we started our great company. These words:

"I do not choose to be a common man. It is my right to be uncommon—if I can. I seek opportunity—not security. I do not wish to be a kept citizen, humbled and dulled by having the state look after me. I want to take the calculated risk; to dream and to build, to fail and to succeed. I refuse to barter incentive for a dole. I prefer the challenges of life to the guaranteed existence; the thrill of fulfillment to the stale calm of Utopia. I will not trade freedom for beneficence nor my dignity for a handout. I will never cower before any master nor bend to any threat; it is my heritage to stand erect, proud, and unafraid; to think and act for myself, enjoy the benefit of my creations and to face the world boldly and say, this I have done. For our disabled millions, for you and me, all this is what it means to be an American."

a highlight in therapeutics



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DISTRICT MEDICAL SOCIETY MEETINGS

WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held at the Larchwood Inn, Wakefield, R. I., October 10, 1956. The meeting was called to order at 11:30 A.M. by the President, Dr. Martin O'Brien.

The minutes of the previous meeting were read and approved.

The following members were present: Doctors S. A. Capalbo, P. J. Celestino, E. T. Gale, C. S. Hathaway, R. J. Kraemer, A. L. Manganaro, J. A. McGrath, L. A. Morrone, Samuel Nathans, T. A. Nestor, M. J. O'Brien, M. I. Robinson, J. R. Tatum, S. J. P. Turco, J. T. Walsh, D. C. Dewees, Z. T. Tang, L. H. Johnson.

UNFINISHED BUSINESS: Dr. Manganaro made a motion that the President appoint a committee of three to study the question of professional fees, to submit a schedule of fees and poll the members of the Society. The motion was seconded by Dr. Dewees, and passed.

COMMUNICATIONS: Communications were read which included portions of the Secretary's letters from the American Medical Association and two letters from Gustavo Motta, M.D., relative to minimum fee schedules.

REPORTS OF COMMITTEES: Dr. McGrath reported on discussions of the House of Delegates in regard to medical care of Military dependents.

Dr. Nathans, reporting on the action of the R. I. Medical Council, stated that the Department of Defense has been given the authority under federal Public Law 569, to take care of various groups of dependents in various areas. The council noted that it proposes to the State Society that Blue Cross and Physicians Service act as agent and be reimbursed by the Department of Defense, and that the fees should not be minimum but average.

NEW BUSINESS: None proposed.

SCIENTIFIC SESSION: Guest speaker was Alex M. Burgess, Jr., M.D., who gave a comprehensive survey of the most recent knowledge on Cardiac arrhythmias of emergency nature in Medicine and surgery.

ADJOURNMENT: Moved by Dr. Capalbo and seconded by Dr. Morrone, the meeting adjourned at 1:30 P.M.

Respectfully submitted,

E. T. GALE, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

A dinner-meeting of the Pawtucket Medical Association was held at the Lindsey Tavern at 6:30 P.M. on October 18, 1956. Doctor Raymond T. Stevens presided.

The following members were present: Doctors Lussier, Jeremiah, Riemer, Metcalf, Webster, Jones, Baron, Eddy, Hecker, Cunningham, Boucher, Edward Foster, Billings, Paull, Bruno, Forgiel, Alexander Jaworski, Kelly, Mara, Morris, Zolmian, Sonkin, Stevens, Gorfine, Pinault and Lovering.

Following dinner, Mr. Allan Bellows gave a short introduction and presented a Tissue Bank Film which had been made at the United States Naval Hospital in Bethesda. The film concerned the technique of preparing bone, arteries, cartilage and skin from donors and subsequent preparation for storage.

The film was received with general applause and it evoked some enthusiastic comment from some of the members present.

The business aspect of the meeting followed. The minutes for the previous meeting were read and approved. Communications were read and included the following:

1. Request of application for admission to the Association by Doctor Mulvaney.
2. Letter from the American Medical Association regarding the Seventh Annual County Medical Societies Civil Defense Conference in Chicago.

Doctor Robert Fortin's application for admission was voted upon and passed unanimously on written ballot.

The Standing Committee's report on change in bylaws as regards the new quorum was deferred as there had been no meeting of this Committee.

Respectfully submitted,

NATHAN SONKIN, M.D., *Secretary*

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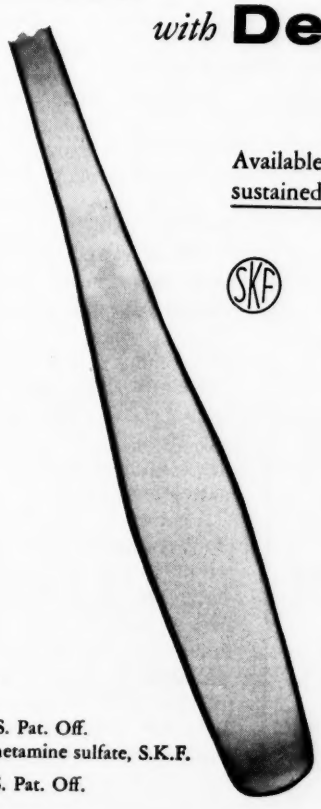

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MEDICAL SOCIETY MEETINGS

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NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held at the Hotel Viking on November 28, 1956. Doctor John M. Malone, President, presided and the meeting was called to order at 8:30 P.M.

The speakers of the evening were Doctor Thomas H. Murphy, Medical Director, Division of Cancer Control, and Doctor Y. S. Song, Associate Director of the Laboratory Staff of the Cancer Cytology Survey. They discussed the Women's Cancer Cytology Survey and noted that it is a research program financed by the federal government, rather than a diagnostic service. The main purpose of this program is to determine how many women over twenty have entirely unsuspected cancer of the uterus. Doctor Song quoted results of previous similar surveys. The project is one of eight now going on in the country. Doctor Song explained the technique of taking and mailing the smears and also discussed the forms which would be used for reporting the results. There was a lively question and answer period.

At the business meeting the minutes of the last meeting were read and approved. A letter regarding Doctor Arthur W. King of Little Compton, urging his nomination as "Country Doctor of the Year", was read and discussed. A communication from the American Medical Association regarding the sponsoring of Science Fairs was read.

Doctor Abramson read the letter which had come from the Assistant Secretary of Defense regarding dependency care in the hospital which will be effective on December 7, 1956. There was considerable discussion as to what will happen on that date. It was apparent that many aspects were still very obscure and unexplained and very much up in the air. It was decided that the Secretary should write a letter to the Assistant Secretary of Defense requesting specific information regarding the actual operation of this act in Newport County, and that he also contact the State Society regarding information about the present status of this act as they understand it.

Doctor Ceppi reported for the last meeting of the State Council, specifically regarding the dependency act, Butler Hospital and the use of Wallum Lake for chest cases other than tuberculosis. Doctor Brownell reported for the House of Delegates. Doctor Grimes spoke regarding the status of ophthalmology throughout the country and described a committee which has been set up to keep an eye on state legislation affecting this specialty.

The meeting adjourned at 10:00 P.M.

Respectfully submitted,
DONALD B. FLETCHER, M.D., *Secretary*

WOONSOCKET DISTRICT MEDICAL SOCIETY

The annual meeting of the Woonsocket District Medical Society was held December 11, 1956, at the Woonsocket Hospital library. Dr. Francis P. Vose presided. Approximately thirty-five members were present.

Dr. Arthur Gaudreau requested information on the present status of the Soldier's Dependents Medical Care Program. Dr. Henri E. Gauthier informed him that he had worked with the committee of the Rhode Island Medical Society that is concerned with this, and that at the present time, the Rhode Island Medical Society and the appropriate authorities in Washington, D. C., are conferring on a fee schedule that will be agreeable to both parties. More specific information will be forthcoming in the near future.

It was pointed out that one of the members of our society is in his eighties, and could use some help from the Benevolent Fund of the State Society. Dr. Gauthier volunteered to present the matter to them.

A complaint was brought up that the physicians of Woonsocket have had a difficult time in the recent Rayon Mill Fire Disaster, and in other disaster situations in Woonsocket, in moving about the city because they have been turned back, rerouted, etc., by the police, Civil Defense workers, National Guard personnel, and State Police. One member recalled that during the flood disaster of 1955, Dr. Halliwell was within two blocks of the Woonsocket Hospital when he was turned back,

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AN ANCIENT GRAPHIC ACCOUNT OF THE CLASSICAL "GRAND MAL" SEIZURE

Oft, too, some wretch, before our startled sight,
Struck as with lightning, by some keen disease
Drops sudden: By the dread attack o'erpowered
He foams, he groans, he trembles and he faints;
Now rigid, now convulsed, his labouring lungs
Heave quick, and quivers each exhausted limb.
Spread through the frame, so deep the dire disease
Perturbs his spirit: as the briny main
Foams through each wave beneath the tempest's ire,
He groans since every member smarts with pain,
And from his inmost breast, with wontless toil
Confused and harsh, articulaton springs.
He raves since soul and spirit are alike
Disturbed throughout, and severed each from each
As urged above distracted by the bane.
But when at length the morbid cause declines,
And the fermenting humours from the heart
Flow back—with staggering foot first treads,
Led gradual on to intellect and strength.

. . . LUCRETIUS (98-55 B.C.)
De Rerum Natura

TENTH CLINICAL MEETING
of the
HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION
At Seattle, Washington, November 27-30, 1956
Report of Delegate

CHARLES J. ASHWORTH, M.D.

THERE is no question in the mind of your delegate that the outstanding contribution to the Seattle meeting of the American Medical Association was the address of President Dwight H. Murray. It is published on page 30. Your reading of it is urgently solicited. The threat to a free people to select a medical adviser, next only in importance to the free choice of a spiritual adviser, was projected with an emphasis that was re-echoed by the press of the entire country.

Strongly condemning government intervention in medicine, Dr. Dwight H. Murray of Napa, California, A.M.A. President, told the opening session that "the medical profession, along with business and industry, is caught between those who desire to promote sound government programs and those who desire even more intensely to perpetuate party politics. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedoms. Medicine must do its utmost to reverse this trend."

Medical ethics, veterans' medical care, radioactive isotopes, continuance of the A.M.A. interim session, hospitalization for patients with alcoholism and a report of the Committee on Medical Practices were among the wide variety of subjects acted upon by the House.

The subject of greatest interest at Seattle was the proposed, ten-section revision of the Principles of Medical Ethics originally submitted at the the June, 1956 Annual Meeting in Chicago, where final action was deferred until the Seattle session. The proposed short version of the principles was resubmitted this week, with some changes based on suggestions received since last June by the Council on Constitution and By-Laws. The House of Delegates, however, decided to refer the matter back to the Council on Constitution and By-Laws for further study and consideration. The reference committee report adopted by the House included the following statements:

"Careful consideration was given to the preamble and the ten sections of the proposed principles. The preamble and seven of the ten sections appear to be acceptable in their present form.

"Sections 6 and 7 were not acceptable as presented either to the group which appeared at the hearing or to your reference committee.

"Out of the general discussion the reference committee received the crystallized opinion that at least four areas needed more specific attention in Sections 6 and 7. These are:

"(1) Division of fees;

"(2) The dispensing of drugs and appliances;

"(3) The corporate practice of medicine;

"(4) Greater emphasis concerning the relationship between physicians and patients.

"In addition, the reference committee felt that the wording in Section 10 could be improved if amended to read as follows:

> " 'The responsibilities of the physician extend not only to the individual but also to society and deserve his interest and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community.'

"In view of the above your reference committee believes that the proposed Principles of Medical Ethics should be referred back to the Council on Constitution and By-Laws for further study and consideration of the above stated principles.

"In the short space of time at our disposal and in view of the importance of the subject, your reference committee did not deem it wise to attempt to properly phrase these concepts.

"We would also recommend that if possible this study be completed at least six weeks prior to the June session and that the new version be published in the JOURNAL in order that all interested physicians might have an opportunity to comment thereon."

Dr. Edward M. Gans of Harlowton, Montana, received the award of 1956 General Practitioner of the Year. The annual award, carrying with it a gold medal and a citation, is presented to a family doctor selected by a special committee of the Board of Trustees for outstanding community service. Dr. Gans, who is eighty years old, has practiced medicine for fifty-one years and has been in the

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NEW

Rheumatoid Arthritis

Ataraxoid*

A.M.A. DELEGATES

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Harlowton area for the past forty-four years.

Veterans' Medical Care

The House revised A.M.A. policy on veterans' medical care by endorsing in principle the following paragraph suggested by the Council on Medical Service:

"With respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated."

This action eliminates the temporary exceptions which were made in the June, 1953, policy regarding wartime veterans who are unable to defray the expenses of necessary hospitalization for non-service-connected cases of tuberculosis or psychiatric or neurological disorders. In making the policy change, the House approved this supplementary statement:

"We recognize the laws and administrative extensions of the law that are now in operation. We feel that under the circumstances it will be to the best interests of the public in general, and veterans in particular, if medical societies, county and state as well as national, develop committees to assist in guaranteeing VA hospital admission to service-connected cases. While the present law exists, we should help assure that veterans whose illness constitutes economic disaster will not be displaced by those suffering short-term remediable ills, which, at the worst, constitute financial inconvenience."

In another action concerning veterans, the House passed two resolutions condemning as unlawful the practice of Veterans Administration hospitals which admit patients who are covered by workmen's compensation insurance or by private health insurance and which render bills for the cost of their care. Both resolutions requested the A.M.A. to take action to bring about a discontinuance of such practices by VA hospitals, and one of them instructed the Association Secretary to obtain from each state testimony or records of each known case that violates VA Reg. 6047-D1.

Radioactive Isotopes

The House rescinded the June, 1951, action, which limited the hospital use of radium and radioactive isotopes to board-certified radiologists, by approving a new policy statement which says:

"(1) In any hospital in which a patient is to receive radium or the products of radium or artificially produced isotopes, there should be a duly appointed Committee on Radium and Artificially Produced Radioisotopes of the hospital professional staff. This committee should include, but not necessarily be limited to, the following qualified physicians: a radiologist, a surgeon, an internist, a gynecologist, a urologist and a pathologist. This committee should have available such competent consultation of other physicians and scientific personnel as may be required by it. Where this is not practicable, the hospital staff should consult the nearest Committee on Radium and Artificially Produced Radioisotopes.

"(2) In any hospital, the use of radium or its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes shall be restricted to qualified physicians so judged by the Committee on Radium and Artificially Produced Radioisotopes of the professional staff to be adequately trained and competent in their particular use.

"(3) It is recommended that procurement, storage, dosimetry control and inventory of all radioactive isotopes for the use of the hospital staff and radiological safety control be centralized, and, where administratively possible, centralization be located in the Department of Radiology.

"(4) It is recommended that the Board of Trustees assign to the appropriate council or committee the continuous study of the problems of radiological safety control in the use of radium and its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes."

Miscellaneous Actions

Among many other actions on a wide variety of subjects, the House of Delegates also:

Urged the widest possible publication and distribution of Dr. Murray's *presidential address* at the opening session;

Pledged the full support of the Association's initiative and energy to President Eisenhower's *people-to-people program* as a means of promoting understanding, peace and progress;

Directed the Board of Trustees to continue its investigation of the practicability of developing a *statement of A.M.A. policies* and to arrange for the periodic publication of revised versions of such a policy statement;

Directed the Councils on Pharmacy and Chemistry and on Foods and Nutrition to conduct a joint study of all presently available information concerning the *fluoridation of public water supplies* and to present a documented report of findings and recommendations at the December, 1957, meeting;

Urged all physicians to participate actively in the formulation of medical policy for *prepaid medical care plans* which are under physician direction or sponsorship;

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A BRIGHAM X-RAY CONFERENCE

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Dr. Levine: He prefers to do it in the teens, before sclerotic changes develop, as well as in these aneurysms. If you make a diagnosis in the teens, say between twelve or fifteen, not when they are too young and the aorta is too small, all right. In the teens, it is a good time to do the surgery. When you come to older people, you are up against the difficulties in the aorta itself.

Dr. Gross had a blowout after a nice, complete, and perfect resection; the wall below was too thin and couldn't take it. That was one of the experiences that led him to work out the graft technique. But, the older they are, the more trouble there is in the aorta operation. You ought to operate before they are thirty.

Chairman Sosman: Before thirty, if possible, and preferably in their teens.

Question: What is the upper limit now? You say it is higher and higher?

Chairman Sosman: I don't know that he has any upper limit. He determines how much arteriosclerosis there is, and if there is aortic insufficiency, that makes it bad. The bigger the heart is, the less chance there is for recovery and successful operation. I don't think he has any fixed limit. He makes the decision on each individual patient.

Dr. Dunphy: Yes. I think the problem is the condition of the aorta, for arteriosclerosis, and sclerotic aneurysm have made it obvious that if the patient will stand the operation, then speaking generally, the future is so poor that it has to be done.

One doctor stated the other day that there is no lesion in any portion of the aorta, from just beyond the coronaries on, that is not amenable to resection, under the techniques today, that is, with the techniques now available.

I would like to comment on the rupture of the vessel in pregnancy, because that is a very intriguing subject, and I am speculating a little bit at the moment; but it is a fact that aneurysms of the splenic artery, about 20 to 30 per cent of them, are discovered ruptured in pregnancy, and that is the way they are brought to light. We all know that during pregnancy, patients undergo remarkable vascular changes; hemangiomas appear on the skin, and I am of the opinion that the ground substance, so-called, which constitutes the complex muco-polysaccharides that make up the vessel walls, undergoes hormonal changes, thus actually weakening the walls.

We have seen patients at the Lying-In Hospital who have come to us with massive, unexplained retroperitoneal hemorrhages, and perhaps they fit into the same category. Some of the hemorrhages are from existing small aneurysms.

It is an intriguing and, I think, fertile field for study.

Chairman Sosman: We have one more case, of a girl with hypertension, what they used to call essential hypertension. She is only eighteen, and she was found on routine examination. She was working in a big department store in Boston, and she was discovered on a pre-employment examination. The blood pressure was 230/132, equal in the two arms. The other thing was that she had numerous pigmented areas and subcutaneous nodules under the skin. The lungs were clear. The heart was enlarged. There were no masses. The retinal arteries were quite normal.

She has neuro-fibromatosis.

Does that fit in with essential hypertension in a young woman, or do you know?

Dr. Dunphy: I am unable to answer that.

Chairman Sosman: Did you ever see it, Dr. Levine?

Dr. Levine: I am not familiar with that.

Chairman Sosman: I think the neuro-fibromatosis is the smoked herring type.

Dr. Dunphy: Might I say that perhaps they have these congenital abnormalities; they may have some others. What about the pulses in the legs?

Chairman Sosman: They are perfectly normal. The blood pressure was a little higher in the leg, as it should be.

Dr. Dunphy: There was no renal disease?

Chairman Sosman: No. The urine was clear.

Dr. Dunphy: The renal functions, and so forth, were done, and pyelograms, too?

Chairman Sosman: Yes. The E.K.G. was normal. Red blood count was 5 million. Why do a pyelogram?

Dr. Dunphy: Well, there are abnormalities of the kidney which may lead to hypertension. Unilateral hypoplasia of the kidney may be associated with hypertension, without an abnormal urine.

Chairman Sosman: I have seen a lot of infantile kidneys, on one side, but functioning normally, and no hypertension. It has got to be more than hypoplasia, I think.

Dr. Dunphy: Still, you would find it out on a pyelogram?

Chairman Sosman: Let us have a look at the X rays.

Dr. Dunphy: Is that an aneurysm?

Chairman Sosman: No. Observe how this is pushed over here. Here is a pyelogram, and it obliterates this here [indicating]; you can barely see it. It could be way out in front or way in the

back. How can we tell without seeing the kidney?

Dr. Dunphy: Take a lateral.

Chairman Sosman: The boy is well-trained. Here it is, here [showing film].

Dr. Dunphy: It is an artery.

Chairman Sosman: It is a calcified artery.

Dr. Dunphy: An aneurysm.

Chairman Sosman: You are pretty close. Dr. Levine, what do you think? The aneurysm almost always has a defect on one side; in other words, they are three-quarters or four-fifths of a circle, and the place they are most commonly seen is in the splenic artery. It is not quite an aneurysm; it looks like a snail.

Dr. Dunphy: What is that picture?

Chairman Sosman: This is the kidney after it was removed. This was taken out and laid alongside the kidney.

Dr. Dunphy: Is that beside the kidney?

Chairman Sosman: This is the kidney.

Dr. Dunphy: Did that come from inside the kidney?

Chairman Sosman: No; from the vein in here [indicating]. It was a thrombus from here. How about the shape of that kidney?

Dr. Dunphy: It looks a little top heavy.

Chairman Sosman: It looks like a hydrocephalous fetus.

Dr. Dunphy: There is too much blood at the top.

Chairman Sosman: The lower half is shrunken, and that is exactly the way you would tie the renal vein, wouldn't you?

Dr. Levine: You would tie the renal artery.

Chairman Sosman: No.

Dr. Dunphy: You have to squeeze the renal artery.

Chairman Sosman: I told Dr. Quinby that this was probably an aneurysm of the renal artery. He found the thrombus in the vein. He said: "At last, I have got one on Sosman." He took the kidney out, and here is the aneurysm of the renal artery.

He said: "If Sosman fell in the water, he would come up with both pockets full of trout."

There is a neurofibroma here in the pelvis [showing film], and they are the ones that really do the damage. Taking out the kidney cured the hypertension. It remained normal the rest of her life. One of the neurofibromas began here [indicating] and she lost the arm, with a neurofibrosed sarcoma. This got bigger and began giving her pain. That killed her; the neurofibrosarcoma eventually killed her.

Ladies and Gentlemen, I hope you have enjoyed this sample of a Brigham Conference.

RHODE ISLAND MEDICAL SOCIETY — NECROLOGY, 1956

VIRGILIO BERTONE, M.D., a practicing physician in Woonsocket for many years, died on December 3, 1955.

Doctor Bertone was graduated from the University of Naples Medical School in 1922, and was licensed to practice medicine in Rhode Island in 1924. He was on the staffs of the Saint Joseph's and Roger Williams General Hospitals in Providence. He served as a lieutenant in the Italian Army.

Doctor Bertone was a member of the Woonsocket Medical Society, Rhode Island Medical Society, and the American Medical Association.

PETER PINEO CHASE, M.D., physician and surgeon, and a man of many interests, but perhaps best known in Rhode Island as Editor-in-Chief of the RHODE ISLAND MEDICAL JOURNAL for fourteen years and as author of the intimate and human column *You and Your Health in* THE PROVIDENCE JOURNAL-BULLETIN since 1946, died on April 23, 1956, at the age of seventy-seven.

He was born in Hyannis, Massachusetts, on August 26, 1878, and he attended elementary school in that town, and high school at Barnstable. He matriculated at Brown University where he was an outstanding athlete and student, graduating with a Bachelor of Philosophy degree in 1906. He entered Harvard Medical School the same year and received his Doctor of Medicine degree in 1910. After internships at Rhode Island Hospital and Boston Lying-In Hospital, Doctor Chase established his office in Providence, devoting his later practice to surgery.

In World War I he went to France with a Harvard Medical Unit, and also served as a surgeon with the British Army. When the United States entered the war he transferred to the AEF with the rank of captain. After the war he resumed his practice in Providence, and he gave willingly of his leisure time to the Providence Medical Association, serving as its Secretary for fifteen years, from 1921 to 1936, when he was elected President of the Association for 1937. He subsequently took over the editorship of the RHODE ISLAND MEDICAL JOURNAL in 1942, and he was President of the Rhode Island Medical Society in 1949-50 when the Society's Physicians Service, a voluntary prepaid medical insurance program, was started.

An outdoor enthusiast all his life, Doctor Chase held membership in the Appalachian Mountain Club, and there were few mountain peaks in the East that he had not scaled. In addition he was an outstanding skier, and winter week ends found him testing his skill on the slopes of the White Mountains.

A lover of classical literature, he was in particular a student of Samuel Johnson and a member of the exclusive Johnson Society. He contributed many fine articles to medical and other scientific publications. He was widely known, and liked by everyone, and the tribute to him by Doctor Joseph Garland, editor of the NEW ENGLAND MEDICAL JOURNAL, is eloquent: "To know Peter Pineo Chase was to love, admire and respect him; he was New England, seasoned and independent; like his literary idol he was one who kept his friendships in repair."

EDMUND D. CHESEBRO, M.D., a practicing physician for more than sixty years, died on November 11, 1956.

Doctor Chesebro was born in Stonington, Connecticut, on March 26, 1863, but had been a resident of Providence for more than fifty years when he died.

He was graduated from the Columbia College of Physicians and Surgeons in 1890 and that same year he opened his practice in Providence.

The doctor was the Rhode Island Medical Society's nominee for the General Practitioner of the Year award given by the American Medical Association in 1948. He was an active member in many clubs and organizations, and was a member of the Rhode Island Medical Society, Providence Medical Association, and the American Medical Association.

ANTHONY M. FEIFER, M.D., died on October 27, 1956, at his home in Barrington, Rhode Island.

Born in Shenandoah, Pennsylvania, Doctor Feifer came to Providence at an early age. He was graduated from the Baltimore Medical College in May 1911, and was issued his license to

practice medicine in Rhode Island in 1912. Doctor Feifer was engaged in the practice of general medicine for forty-three years on Broadway in Providence.

He was a member of the Rhode Island Medical Society, Providence Medical Association, and the American Medical Association.

ALBERT C. HENRY, M.D., for many years a general practitioner in Wickford, died on August 16, 1956.

Doctor Henry was born in Bethlehem, Pennsylvania, on November 24, 1903. He was graduated in 1926 from Muhlenberg College in Allentown, Pennsylvania, and in 1930 from Hahnemann Medical College and Hospital in Philadelphia. He began his practice in Wickford in 1931.

He was at one time president of the South County Hospital and a staff member of the Roger Williams General Hospital in Providence. He was a member of the Rhode Island Medical Society, the American Medical Association, and was a past president of the Washington County Medical Society.

HENRY A. JONES, M.D., former assistant director of the State Department of Social Welfare, and former official at several state institutions at Howard, died at his home on South County Trail on January 15, 1956.

Doctor Jones was born in Liverpool, England on January 31, 1870. He was graduated from the Bowdoin College Medical School in 1896 and completed a postgraduate course at Harvard Medical College. His internship was served at the state hospital at Howard.

He was named assistant physician at the State Hospital for Mental Diseases, serving from 1898 to 1904, as resident physician there from 1904 to 1916, and as superintendent at the State Infirmary from 1916 to 1924, and he then conducted a private practice in Cranston. While practicing there Doctor Jones accepted the post of Cranston Health Superintendent.

He was former president of the Rhode Island Medico-Legal Society, the first president of the Cranston Medical Club, and he was a member of the Rhode Island Medical Society, the Providence Medical Association, and the American Medical Association.

WILLIAM N. KALCOUNOS, M.D., a prominent Pawtucket physician, died on April 12, 1956.

Doctor Kalcounos was born in Pawtucket on October 15, 1912, and he attended local schools there. He was graduated from the St. Louis University Medical School in 1939. He served his internship at the St. Mary's Group Hospital in St. Louis. He then started private practice in Pawtucket.

He was a member and past president of the Pawutcket Medical Association, and a member of the Rhode Island Medical Society.

JAMES P. LONDERGAN, M.D., a Providence physician for more than twenty-five years, died on September 5, 1956.

Doctor Londergan was born in Providence and attended Providence College for a two-year premedical course. He was graduated from Georgetown University Medical School in 1930.

Doctor Londergan interned at Saint Joseph's Hospital and served on that staff and also the staffs of the State Hospital for Mental Diseases and the Roger Williams General Hospital.

He served with the United States Navy Medical Corps during World War II. He was a member of the Rhode Island Medical Society, the Providence Medical Association, and the American Medical Association.

JAMES S. MOORE, M.D., one of the oldest general practitioners in the state, died at the age of eighty-five on October 2, 1956.

Doctor Moore was born on March 3, 1871 in South Royalton, Vermont. He was graduated from Harvard Medical School in 1898 and began his general practice in East Providence that same year.

He was past president of the East Providence Business Men's Association and a member of the United Congregational Church. He also served at various times on the Town Council, and on the School Committee, and as Health Officer of the town.

Doctor Moore was a member of the Providence Medical Association, Rhode Island Medical Society, and the American Medical Association.

JOHN V. O'CONNOR, M.D., physician and surgeon, died at the age of seventy-one on September 8, 1956.

Doctor O'Connor was born in Blackstone, Massachusetts, but had lived in Woonsocket most of his life. He attended the College of Physicians and Surgeons and upon graduating in 1911 he undertook postgraduate work at the Johns Hopkins Medical School. The doctor served his internship at the Mercy Hospital in Blackstone and he served on the staff of the Woonsocket Hospital.

Doctor O'Connor was a past president of the Woonsocket Medical Society, and he was a member of the Rhode Island Medical Society.

A.M.A. DELEGATES

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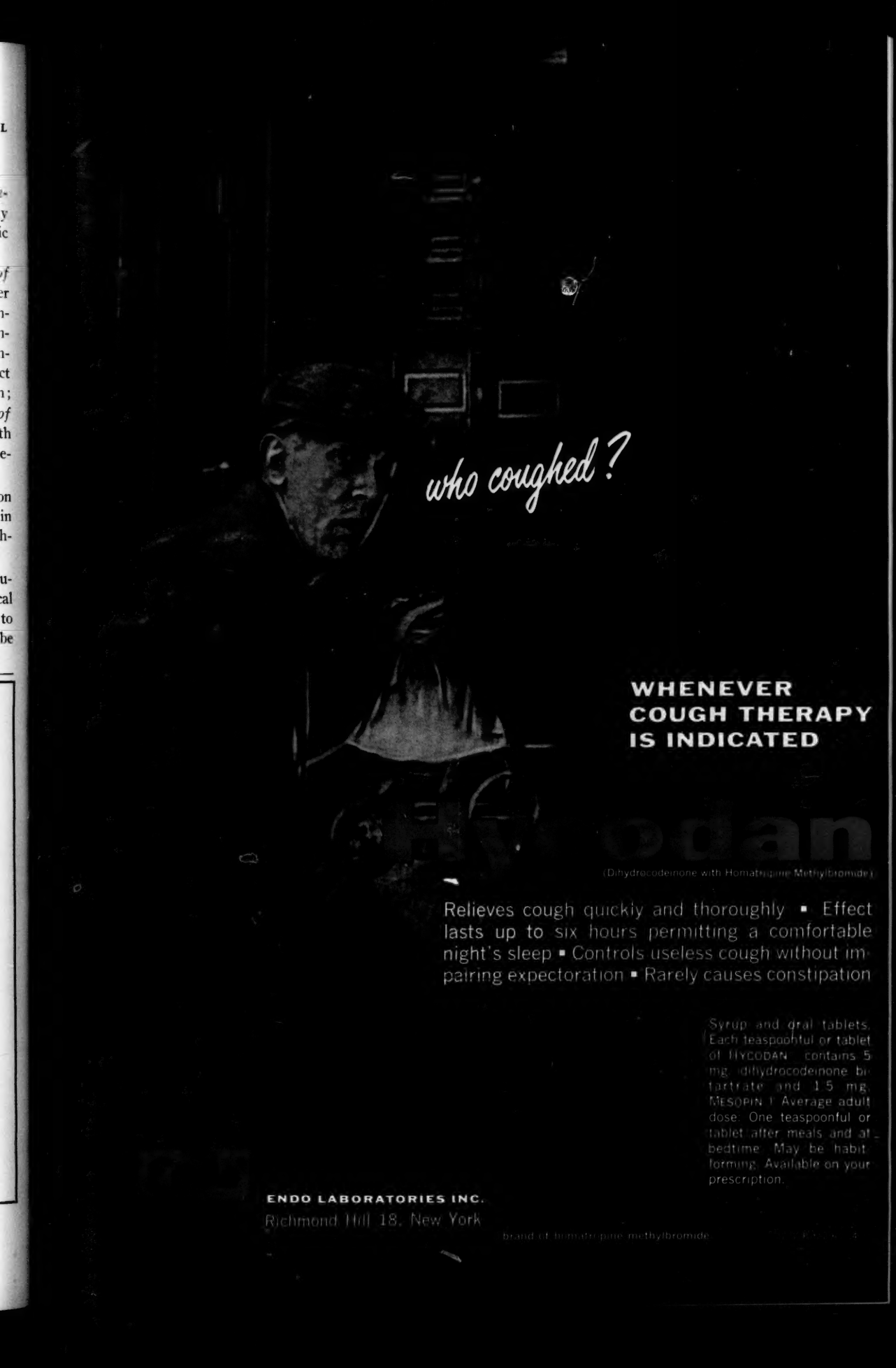
Changed the By-Laws to extend *service membership* to reserve officers on extended active duty with the defense forces and the U. S. Public Health Service;

Changed the By-Laws relating to *transfer of membership* so that an active or associate member of the Association who moves his practice to another jurisdiction may continue his A.M.A. membership by applying for membership in the constituent association in his new jurisdiction, subject to a two-year limit on approval of his application;

Changed the By-Laws so that the *election of officers* may take place at any time on the fourth day of the annual session, instead of being restricted to the afternoon of that day;

Approved the principle of a voluntary reduction in the self-assigned *quota of interns* as printed in the 1956 handbook of the National Intern Matching Program, and

Instructed the Board of Trustees to accentuate cooperation between the American Medical Association and the American Bar Association to the end that a bill of the *Jenkins-Keogh* type be enacted at the next session of Congress.


who coughed?
WHENEVER
COUGH THERAPY
IS INDICATED
(Dihydrocodeinone with Homatropine Methylbromide)
Relieves cough quickly and thoroughly ▪ Effect lasts up to six hours permitting a comfortable night's sleep ▪ Controls useless cough without impairing expectoration ▪ Rarely causes constipation
Syrup and oral tablets. Each teaspoonful or tablet of HYCODAN contains 5 mg. dihydrocodeinone bitartrate and 1.5 mg. MESOPIN † Average adult dose: One teaspoonful or tablet after meals and at bedtime. May be habit forming. Available on your prescription.
ENDO LABORATORIES INC.
Richmond Hill 18, New York
† brand of homatropine methylbromide

THROUGH . . .  *the Microscope*

Jenkins-Keogh Bill Favored

According to the Washington Office of the A.M.A., all 435 members of the 85th Congress have been polled on the principles of the Jenkins-Keogh bills for tax deferment on money paid into annuity plans. The American Bar Association's committee on retirement benefits reports that more than half the members favor such legislation, only three members were opposed, 18 are noncommittal, and 120 did not reply to the question.

Representative Eugene Keogh (D. N.Y.) is expected to introduce a new version of the proposal this month. The A.M.A. has supported Jenkins-Keogh type of bills since 1948 in the belief that the self-employed are now discriminated against. The tax laws permit employers to set aside limited sums of money for their employees on a deferred tax basis, but this is denied the self-employed. Physicians are urged to write their Congressional delegation in Washington to urge passage of the Jenkins bill.

Dimes for Polio Vaccine in 1957

The National Foundation for Infantile Paralysis expects 3 million "marching mothers" to visit personally 40 million homes through the country the last week of this month to receive contributions and to launch a broad scale vaccine education program. Families will be urged to have polio shots, and each home visited by the marchers will be presented a record card to provide listing of the entire family's vaccination status including the proper dates for each of the three necessary inoculations. The program of adult education is in line with the current expert recommendation that everybody, at least up to the age of forty, should avail themselves of polio vaccination.

Report on American Physician-Legislators

The Washington Office of the A.M.A. has done an interesting report on doctors in government who have served in the U. S. House or Senate. Noting that five doctors signed the Declaration of Independence, the report concludes with the information that six physicians are included in the 85th Congress now in session. Counting these six recently elected Representatives, a total of 359 physicians have served in the American Congresses since 1775, including 35 Senators. Of this group 165 were Democrats; 67, Republicans; 30, Whigs; 17, Federalists; 6, Jacksonian Democrats; 5, American Party; 2, National Republicans; 2, Independents; and one each from six other minor parties. There is no record of party affiliations for 32 doctors in Congress, and party labels were not attached to the 27 who sat in the Continental Congress between 1775 and 1788. Rhode Island lists among her physician-legislators a doctor who served two terms in the Congress—Doctor Thomas Tillinghast of East Greenwich, 1797-99, and 1801-1803.

Medical Aspects of Civil Defense

Representatives of 30 states were in attendance in Chicago last November at the 7th annual conference on Civil Defense sponsored by the A.M.A. Council on National Defense for county medical society CD organization personnel. Designed to help local medical authorities in the over-all planning for disaster, civilian or military, the conference gave particular attention to the changing concept of the handling of atom or hydrogen bomb casualties. The newer weapons, including flying missiles, have altered the earlier planning of a direct bomb hit in a restricted area. Present thinking indicates that with or without warning 90% of the people in the immediate central zone affected will be killed, and 65% of the survivors of the blast effects will sustain second-degree burns. The medical care of casualties will have to be concentrated on people who have a possible chance of survival from their injuries. This month a report on the broad concepts of medical care under the civilian defense program is to be issued by the national planning body.

Ethics Code Gets Further Study

At the Clinical Session of the A.M.A. in Seattle the new simplified version of the Principles of Ethics deferred from the Chicago meeting of last

June for action at the Interim Session, again was turned back for further study. Hearings before the reference committee of the A.M.A. House of Delegates brought out so many divergent opinions on some of the provisions, the House voted to send the ten-point code back to the Council on Constitution and Bylaws for further study.

Industrial Health Meeting Planned

Safeguarding the worker's health will be the chief consideration of representatives of labor, management, government and the medical profession at the 17th annual Congress on Industrial Health to be held February 4-6 at the Biltmore Hotel, Los Angeles. Sponsored by the A.M.A.'s Council on Industrial Health, the Congress is open to all physicians, nurses, industrial hygienists, engineers and others interested in occupational health.

A special session on *Vision in Industry* will be presented Monday afternoon, February 4, and Tuesday morning, February 5, in cooperation with the National Society for the Prevention of Blindness. This presentation will cover such things as the components of a vision program, evaluation of vision screening methods, testing for color perception, estimation of loss of visual efficiency, relationships between illumination and vision, the successful eye protection program, prescription safety goggles, emergency treatment of eye chemical injuries, screening for eye disease, and responsibilities and limitations of the industrial nurse in a vision program.

Hendricks Named A.M.A. Field Director

Thomas A. Hendricks, known widely to physicians as the secretary of the Council on Medical Service of the A.M.A. has been named to the newly-created post of field secretary of the A.M.A. to interpret the national association's policies and programs for state and county medical societies, and at the same time to transmit to the headquarters and the A.M.A. trustees up-to-the-minute reports on local problems and attitudes. Mr. Hendricks is remembered by many Rhode Island physicians and their wives, as he has addressed both Society and Auxiliary meetings here. He has been a medical executive for thirty-two years, and served the Indiana State Medical Association prior to moving up to the A.M.A. headquarters in 1945.

Fluoridation Due for Re-evaluation

A proposal to the House of Delegates of the A.M.A. at the Seattle clinical session that the Speaker of the House be authorized to appoint a special *ad hoc* committee to conduct a thorough study of all pertinent presently available information concerning the fluoridation of public water

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supplies, said committee to report at the meeting in New York next June, won surprising support. However, the Delegates, noting the need for a re-evaluation of the program, asked that the Board of Trustees direct the Councils on Food and Nutrition, and on Pharmacy and Chemistry, to conduct a joint study of all data and present a report at the interim clinical session scheduled for Philadelphia next December.

110 Million Have Health Insurance

The Health Information Foundation reports that by mid-1956 approximately 110 million Americans, almost 70% of the population, were protected or "covered" by some form of voluntary health insurance. This means, according to the Foundation, that in a little more than twenty-five years almost as many people had purchased insurance to help pay the costs of hospital care and physicians' services as comprised the total U. S. population in 1930, when the voluntary health insurance movement began.

Meanwhile the Institute of Life Insurance reports that about 40% of the employees in civilian, non-agricultural establishments throughout the nation are now covered by some form of pension plan, in addition to whatever coverage they have under the Social Security Act.

Rhode Island Anesthesiologists Elect Officers

At the annual meeting of the Rhode Island Society of Anesthesiologists, held on November 28, the following physicians were elected as officers for the year 1957: Samuel Pritzker, M.D., *President;* William C. Howrie, M.D., *Vice President;* William A. McDonnell, M.D., *Secretary-Treasurer;* and Samuel Nathans, M.D., *Director for District 4.*

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Food and Drug Administration
Washington 25, D. C.

STATEMENT ON HOXEY CANCER TREATMENT

By Geo. P. Larrick
Commissioner of Food and Drugs

For the second time, a Federal court has determined that the Hoxsey medicines for internal cancer are worthless. On November 15, 1956, after a six-week trial in the Federal court at Pittsburgh, the jury returned a verdict that these medicines, in pill form, were illegally offered as an effective treatment for cancer. On November 16, U. S. District Judge John L. Miller signed an order of condemnation stating that the pills were misbranded as charged by the Government and ordering their destruction.

The public should know, however, that this action does not end the menace of this fake treatment. It merely means that half a million of the Hoxsey pills, which were seized shortly after the opening of a second Hoxsey Clinic at Portage, Pa., will now be destroyed. An injunction is being sought to stop further interstate shipment of the pills. We intend to use every legal means within our power to protect consumers from being victimized by this worthless treatment.

In the meantime it is of the utmost importance that cancer patients and their families, who may be planning to try the Hoxsey treatment either at Dallas, Texas, or Portage, Pa., should acquaint themselves with the facts about it. All such persons are advised to secure a copy of the Public Warning which was issued by the Food and Drug Administration last April. They may do this by writing to the Food and Drug Administration, Washington 25, D. C.

Harry M. Hoxsey has continued to promote his worthless cure for more than 30 years, notwithstanding numerous local and state court actions. Proceedings under the Federal Food, Drug, and Cosmetic Act did not appear possible until a 1948 decision of the Supreme Court interpreting the word "accompanying" in the definition of labeling under the Act. An injunction suit was filed in 1950 and a decree finally issued by the Federal court at Dallas in 1953.

Over the years thousands of persons have been deceived by the false claims for the Hoxsey liquid medicines and pills. At the Pittsburgh trial there was testimony concerning persons who may have died of cancer as a result of reliance on the Hoxsey treatment instead of seeking competent medical treatment in the early stages of their condition.

The Government's evidence showed that alleged "cured cases" presented by defense attorneys were people who either did not have cancer, or who were adequately treated before they went to the Hoxsey clinic, or who died of cancer after they had been treated there.

November 23, 1956

WOONSOCKET MEDICAL SOCIETY

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suffering a two-hour delay before he finally reached the hospital. This delay was completely unnecessary, as the way was passable and utility trucks, etc. were being allowed through.

Dr. Francis P. Vose was appointed chairman of a committee to obtain police passes, CD identification, and CD stickers for our cars, so that we may not be delayed in the future in taking care of the casualties and the sick in the event of any future disaster.

The next order of business was the election of officers for the coming year. President Francis P. Vose appointed Doctors Joseph W. Reilly, Auray Fontaine, and Ernest L. Dupre as a nominating committee. They presented the following slate, which was unanimously elected.

President ..... Dr. Richard H. Dowling
Vice-President ..... Dr. Charles E. Brochu
Secretary ..... Dr. Alton P. Thomas
Treasurer ..... Dr. Paul E. Boucher
Councillor ..... Dr. Saul A. Wittes
Delegates ..... Dr. Henri E. Gauthier
Dr. Thomas J. Lalor
Censors ..... Dr. Francis J. King
Dr. Victor H. Monti
Dr. Auray Fontaine

The meeting adjourned at 9:30 P.M. Refreshments were served in the hospital cafeteria.

ALTON P. THOMAS, M.D., *Secretary*

BOOK REVIEWS

PATHOLOGIC PHYSIOLOGY. Mechanisms of Disease. Edited by William A. Sodeman, M.D. W. B. Saunders Company. 2nd ed. Phil., 1956. $13.00

This volume approaches the study of disease by a thorough integration of the basic mechanisms involved. While diagnosis and treatment are not presented separately, the pathologic and physiologic discussion of the alterations in the bodily economy which constitutes disease, results logically in a grasp of these applications.

Although the text is a compilation of separate contributions by various authors, a uniform readability exists which is unlike usual textbook presentations. Textual references are few, but there is, however, a fairly complete bibliography at the end of each chapter. Even though there are 931 pages of text, it is evident that very few subjects could be given an exhaustive treatment. Therefore, it is to be regarded not primarily as a reference work but an excellent series of reviews of such broad subjects as the alteration of the course of an infection, the applied physiology of the endocrine glands, hemodynamics, respiratory function, the gastrointestinal tract and accessory organs, and similar system physiology. In addition to its educational value per se, the treatise can well serve as an excellent review for those planning to take specialty board examinations in internal medicine and allied fields.

IRVING A. BECK, M.D.

BELLEVUE IS MY HOME by Salvatore R. Cutolo, M.D. Doubleday & Company, Inc., Garden City, N. Y., 1956. $4.00

As one who spent three years in a dermatology residency at Bellevue Hospital, I started reading Doctor Cutolo's book, BELLEVUE IS MY HOME, with anticipation of a delightful reliving of many of my own experiences there. Unfortunately, however, the book was not primarily written from the point of view of a house officer, so that completion of the reading was attended by a feeling of disappointment.

It goes without saying that this criticism is unfair since Doctor Cutolo, as Deputy Medical Superintendent, could hardly be expected to approach his subject from the point of view of a resident. The book presents a review of the functions and departments of Bellevue as seen through the eyes of a hospital administrator. As a result, one gets the impression that it is somewhat superficial in its approach. Throughout are interspersed case reports and human interest stories which give some warmth and color to an otherwise cold presentation. As I think back to my days at Bellevue I can recall most vividly the innumerable daily events and unusual patients that made the hospital as vibrant, warm and colorful as it was.

And so, returning to my original theme, the book offers the type of report that might be expected from one in an administrative position. It interestingly presents an over-all picture of a large hospital with just enough human interest stories thrown in to make pleasant reading for the lay person. However, as a physician, particularly one who spent three years of his life there, it is my opinion that the book falls far short of the possibilities and that a wealth of material lies untapped.

ARTHUR B. KERN, M.D.

PHYSICAL DIAGNOSIS by Ralph H. Major, M.D. and Mahlon H. Delp, M.D. 5th ed. W. B. Saunders Company, Phil., 1956. $7.00

This is a neat, compact book by a well-recognized longtime student and teacher of medical history and physical diagnosis, in coilaboration, in this edition, with a professor of medicine who has worked with the senior author for years. It is a very orderly textbook. The text is erudite; illumined by many historical references. A selected but wide ranging and well-covering bibliography is inserted at the end of almost every chapter.

The book is profusely illustrated by small but clear black and white diagrams and pictures, mostly photographs of actual patients. The profuseness of illustration is indicated by the fact that there are 536 numbered illustrations in about 320 pages of the text, and that on a single page there may be as many as five photographs along with some text.

The text is evidently aimed at students, and I believe every medical student should become familiar with the book. More mature physicians may